



Canadian Hospital

The Canadian Hospital Association is the federation of hospital associations in Canada and the Canadian Medical Association in co-operation with the federal and provincial governments and voluntary non-profit organizations in the health field.

THE JOURNAL OF THE CANADIAN HOSPITAL ASSOCIATION

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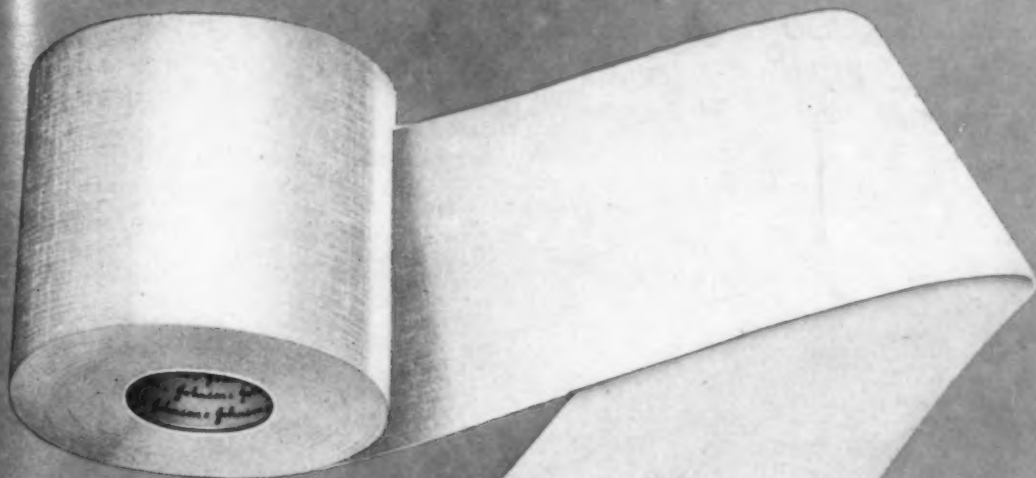
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Notes About People

G. A. W. Currie, M.D.

Dr. George A. W. Currie, administrator of the Hospital for Sick Children, Toronto, Ont., died suddenly July 15, 1959. He was 46 years of age.

A native of Picton, Ont., Dr. Currie graduated in medicine from Queen's University, Kingston, in 1938. After interning at the Regina General Hospital, Regina, Sask. he enlisted and served with the Royal Canadian Army Medical Corps during the second world war. He next enrolled at Columbia University and graduated with a Master's degree in hospital administration. He then accepted an administrative post at Colorado Medical Centre, University of Colorado, Denver, and subsequently became administrator of the University Hospitals at the University of Texas in Galveston, Texas. It was in September, 1957 that Dr. Currie came to the Hospital for Sick Children in Toronto as administrator. He was also chairman of the C.H.A.'s Committee on Education.

Appointed to Montreal Neurological

Dr. William Feindel, professor of neurosurgery at the University of Saskatchewan, has been appointed professor of neurosurgery at McGill University and neurosurgeon at the Montreal Neurological Institute. He will fill the vacancy left by the death of Dr. William V. Cone, co-founder, with Dr. Wilder Penfield, of the Institute.

Dr. Feindel, a former fellow and staff member of the Montreal Neurological Institute, left Montreal in 1955 to develop the department of neurosurgery at the University of Saskatchewan in Saskatoon. In Montreal he had served as lecturer in neurosurgery and neurology at the Institute where he had received his training.

He is a native of Nova Scotia and received his B.A. from Acadia University, Wolfville, and an M.Sc. from Dalhousie University in Halifax. He received his M.D.C.M. from McGill in 1945. He was also a Rhodes Scholar and was awarded a D.Ph. at Oxford in 1949.

Attended Development Program

Philip Rickard, executive director of the Saskatchewan Hospital

Association, was awarded a fellowship at Cornell University by the Sloan Foundation. This award enabled Mr. Rickard to attend a special hospital administrators' development program there from June 22 to July 31. Several countries outside of the United States were each allocated one fellowship—Mr. Rickard represented Canada—which allowed these men to attend the session along with prominent hospital administrators in the United States.

Receives Travel Award

Dr. John C. Beck, head of the endocrine metabolism department at the Royal Victoria Hospital, Montreal, Que., and assistant professor of medicine at McGill University, has been named laureat of the Perdu Frederick Medical Achievement Travel Award. He is the first Canadian to receive this honour.

Dr. Beck is one of the pioneers of research in the field of growth hormones in man, and he has written for several international medical and scientific journals. The award will enable him to give lectures and attend scientific meetings in medical research centres in England, Scotland, Sweden, Denmark and Germany.

Jackson R. Bryan Leaves Welland Post

Jackson R. Bryan, who has been superintendent of the Welland County General Hospital in Welland, Ont., for the past five years, has resigned his post.

Mr. Bryan, a native of Port Arthur, Ont., was educated at the



Jackson R. Bryan

Royal Military College at Kingston, Ont., and obtained a B.A. at the University of Toronto. He also holds an M.A. degree in psychology from the same university. He served with the R.C.A.F. during the second world war. Before his war service Mr. Bryan supervised the cultivation of a plantation in Trinidad, was assistant superintendent of the police in Port of Spain, an officer in the fire brigade and acted as A.D.C. to his Excellency Sir Murchison Fletcher in Trinidad.

Elected President of the C.H.A.C.

Rev. Raymond Durocher, O.M.I., Bishops' representative for the Catholic Hospital Conference of Manitoba, of Winnipeg, was elected president of the Catholic Hospital Association of Canada at their biennial convention. Father Durocher, an American by birth, was educated at the Juniorate of the Holy Family, St. Boniface, St. Paul's College in Winnipeg, Man., the Oblate Scholasticate in Lebreton, Sask., Marquette University at Milwaukee and Fordham University in New York. He has been Bishop's representative to the Catholic Conference of Manitoba since 1955, and is one of nine members of the Manitoba Hospitals' Council, advisory to the Minister of Health and Welfare of the province. He is also chairman of the Research and Coordination Committee of the Manitoba Conference. He succeeds the Rev. J. B. Nearing, Bishops' representative of the Maritime Conference, and a recently elected member of the board of the C.H.A., as president of the Catholic organization.

Named vice-presidents of the association for the 1959-61 term were Sister M. Clarissa, St. Rita Hospital, Sydney, N.S.; and Sister Richard, Hôtel-Dieu de St-Hyacinthe, St-Hyacinthe, Que. Mother Ste-Marie-Madeleine, Montmagny, is secretary; and Sister Elizabeth Marie, Ottawa, was retained as treasurer. Councillors are Sister Mary Angelus, St. Joseph's Hospital, Victoria; and Sister Margaret Marie, Holy Family Hospital, Prince Albert, Sask.

Saul Raxlen, M.D.

Dr. Saul Raxlen, general practitioner in charge of the Raxlen Clinic, Toronto, Ontario, and treasurer of the board of directors of the Doctors' Hospital, Toronto, died on June 15, 1959, after a

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People

(continued from page 14)

long illness. He was 47 years old.

Born in Toronto, Dr. Raxlen was a graduate in medicine from the University of Toronto in 1936. Following his internship he formed the Raxlen Clinic with his three brothers and later, with them, established the Doctors' Hospital.

He served with the Royal Canadian Army Medical Corps, as a major, in the second world war.

First Red Cross Fellowship Awarded

Helen M. Carpenter, assistant



Helen M. Carpenter

professor of the School of Nursing, University of Toronto, has been awarded the first Canadian Red Cross Fellowship for graduate study in nursing. Miss Carpenter will follow a program leading towards certification for doctor of education at Columbia University, New York.

Miss Carpenter, born in Montreal, Que., was educated in Alberta and British Columbia, and received her diploma in nursing from the Toronto General Hospital, and her diploma in public health nursing from the University of Toronto in 1933. In 1943 she obtained a bachelor of science degree from Teacher's College, Columbia University. Two years later she was given the degree of master of public health from Johns Hopkins School of Hygiene and Public Health and was awarded a Rockefeller Foundation Fellowship.

In 1933-34, she was with the Ontario Red Cross Outpost Hospital Service, and then was with the Victorian Order of Nurses in Hamilton and Toronto as staff nurse, supervisor, and assistant director. Later she served as consultant in public health nursing to the British Columbia Department

of Health, 1943-44. She returned to Ontario as director of public health nursing at the East York-Leaside Health Unit in 1945 where she was until her full time appointment to the University of Toronto School of Nursing in 1948.

Changes at Cornwall

Myrtle Morell has left her post as assistant administrator and secretary to the board of governors of the Cornwall General Hospital, Cornwall, Ontario. Mrs. Morell, a graduate of the C.H.A.'s extension course in hospital organization and management, has been with the Cornwall hospital for nine years, having first joined the staff in 1950 as business administrator and secretary-treasurer. The Morells now reside in Carleton Place.

C. A. Wright, who has been accountant at the Cornwall General Hospital since 1950, has also left to go to Ottawa.

New Administrator at Fort Erie

W. F. Thompson is now administrator of the Douglas Memorial Hospital in Fort Erie, Ont.

Born in Oak Ridges, Ont., Mr. Thompson received his education in Aurora and Toronto. After ser-

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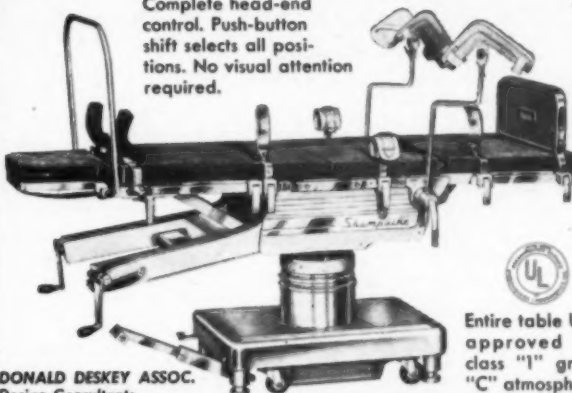
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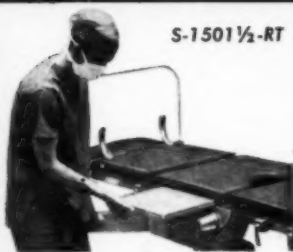
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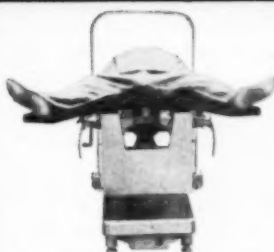
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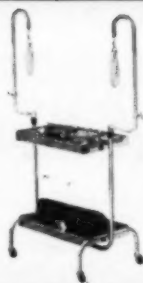
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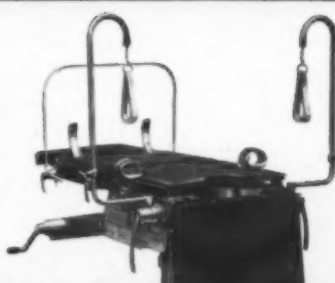
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proposed

People

(concluded from page 24)

ving for three and a half years in the Far East with the R.C.A.F., he joined the staff of the Ontario Hospital Association, Blue Cross Division. After four and a half years he was appointed credit and office manager of the Peterborough Civic Hospital, where he set up a personnel department and acted as personnel director and assistant administrator. In going to Douglas Memorial, Mr. Thompson leaves the post of administrator of the Kirkland Lake and District Hospital, Kirkland Lake, Ont.

Director of Nursing Retires At North Bay

Mary Reidhead who has served as director of nursing at the North Bay Civic Hospital since October 1951 has retired. Miss Reidhead graduated from the old Queen Victoria Memorial Hospital training school in North Bay, Ontario, in 1921, and for the first eight months after served as night supervisor at the hospital. During her training years she took a four-month course in V.O.N. work at Montreal, and for a few years she relieved the V.O.N. nurses in North Bay during

their holidays. She worked as a private duty nurse until 1927 when she went to New Brunswick to work at the Soldiers' Memorial Hospital, in Campbellton until 1934. Miss Reidhead returned to North Bay, and in 1937 she joined the Civic Hospital's staff as night supervisor. In 1951 she assumed the post of director of nursing.

Appointed at Princess Margaret Hospital

Dr. Harold Warwick has been appointed deputy director of the Princess Margaret Hospital, Toronto, Ont. Dr. Warwick, a native of Saint John, N.B., has been medical director of the National Cancer Institute of Canada and the Canadian Cancer Society since 1948. Since 1954 he has been the representative of Britain on the International Cancer Research Commission.

He graduated from Mount Allison University, where he was awarded a Rhodes Scholarship in 1936. He served with the R.C.A.F. during the second world war, and in 1946 he was the recipient of a Nuffield Travelling Fellowship and spent 15 months in study at cancer research and treatment

centres in Great Britain, France and the Scandinavian countries.

Director for Family Allowances In Manitoba

W. F. Hendershot, who for the past two years has been executive assistant to the Deputy Minister of Welfare, has been appointed regional director, Family Allowances and Old Age Security, for Manitoba.

Mr. Hendershot first joined the civil service in 1946, when he served as executive assistant to the national director of family allowances and old age security. During this time with the Department of National Health and Welfare he was for several years regional director of family allowances and old age security for the Yukon and Northwest Territories. He has also served as acting regional director of family allowances and old age security in Fredericton, New Brunswick, and in Halifax, N.S.

New Urologist at Royal Victoria

Dr. Kenneth J. MacKinnon has been appointed urologist-in-chief to the Royal Victoria Hospital. Dr. MacKinnon, who comes from An-

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W. Douglas Piercey, M.D., Editor



Obiter Dicta

"Canadian Hospital" belongs to you

It is through your hospital associations, provincial and national, that the hospitals of Canada receive those benefits which only fully co-operative, non-profit organizations can provide. Your national association, in co-operation with your provincial association, brings to you comprehensive educational programs, institutes and workshops. It offers a library service which is much in demand and publishes annually an up-to-date directory of hospitals. Further, each month, *i.e.*, 12 times a year, your journal *Canadian Hospital* makes its appearance. In all these activities you have a share—but we are thinking now most particularly of the journal—your journal.

Now, for the first time in 20 years, *Canadian Hospital* faces direct competition in the form of a publication which purports to serve the hospital field in Canada—but which is being distributed for purely commercial purposes. This development need cause no alarm because the strength of *Canadian Hospital* lies in the fact that it belongs to the hospitals of Canada. Its purpose (one common to all association activities) is to foster continuous improvement in hospital care through free interchange of ideas.

How can you personally help in this joint effort? When you prepare a paper for presentation to any hospital group, you can give preference to your own journal in the matter of publication rights. You can, as so many of you already do, contribute original articles for the benefit of others in the field. New construction designs, improved techniques, and news of changes taking place in your hospital are always stimulating to your colleagues. Do not forget that your staff members who have specialized knowledge are also welcome contributors. Bear these points in mind and you will be supporting your associations and your own journal.

There is one more important consideration. Publication of a monthly journal is extremely costly. In fact, it would scarcely be possible in its present format were it not for the hospital supply houses who purchase advertising space. We are proud of their loyalty and support throughout the years. They would like your assurance that you do read the journal. You can help by saying occasionally "We saw this advertised in *Canadian Hospital*." Continued progress and prosperity for your journal depends on the sustained interest and co-operation of us all.

Integrated care

THE administrator must deal with people as a group, although as human beings, people should be treated as individuals. Here lies his problem. People do not fit neatly into groups, nor do their diseases fit neatly into specific categories. For example, the convalescent patient's condition can deteriorate to the point when he should be transferred to the long-stay hospital, or the condition of a patient with a chronic disease can suddenly become acute and he warrants transfer back to the active hospital. These transfers are facilitated if the special hospital is affiliated with, or a part of, the acute general hospital.

A hospital restricted to the care of certain types of disease must necessarily be geared to meet the demands of only a limited number of sick and injured people. It is limited in services, equipment and staff, and should properly care for only those patients who fall into its specific category. Since the variations and complications of human disease are almost infinite, very few patients are suffering from only one specific illness. Therefore they should not be cared for in a special hospital, but instead in a general hospital which offers a well-rounded diagnostic and therapeutic service. These are the factors which have led to the trend away from the special hospital and toward the establishment of an integrated care system based upon the acute general hospital. Dr. W. I. Taylor, executive director of the Canadian Council on Hospital Accreditation said in a speech to the Maritime Hospital Association in June 1959: "Things they cannot do well and which could be done better in a larger hospital should not be attempted in small hospitals".

There are a number of advantages to be gained by an integrated care system. The administration of a combined unit may achieve *economy of operation* by avoiding unnecessary duplication of facilities. The economies of bulk purchasing and efficient staff organization are also made possible. Under an integrated care plan *referrals* are made easy. The patient may be referred quickly from one unit to another under the same administration. The difficulties and delays of patient transfers are reduced to a minimum. Also, under an integrated plan the patient receives the *care* he requires since he may be easily transferred to that section that has the facilities, the equipment and the personnel to care for his particular condition.

Complete integrated care would mean that each hospital is able to supply all services. This ideal, however, must be limited by practical considerations. It would not be practical for all hospitals to meet all needs. For example, it would not be practical for the small rural hospital to provide a cardiac clinic. Therefore integrated care should be supplied only by the large hospital—but this care should be as complete as possible. In addition to supplying the more advanced medical departments, such as a cardiac clinic or a therapeutic x-ray department, the hospitals should provide accommodation through wings, out buildings, or separate affiliated hospitals, for the care of convalescent and rehabilitative patients, for the care of chronic and long term patients, and for the care of psychiatric patients. In doing this, the hospital will benefit by removing from its active wards long-stay patients, and by effecting a number of economies of operation. The medical and nursing staffs will benefit by being provided with a fruitful field of study. The

patient will benefit by receiving the medical and nursing care which he requires for his specific condition. It is up to the large hospitals to take the lead in providing this type of care with its benefits to the patients, to the hospital, and to medicine.—G. McC.

Children and safety

GREAT strides have been made in the improvement of the health of our children. We, as Canadians, pride ourselves on this advance. Scourges of the past, such as diphtheria, have been conquered, and today not nearly so many children die of communicable diseases. However, many young lives are needlessly lost each year through accidents.

Accidents are the leading causes of death among children—highway accidents, fires, drownings, and poisons lead the list. Many of these accidents are ones which could have been prevented, for there is much to be done in educating parents and children on the prevention of these hazards. Recently, the newspapers have made much of several deaths by suffocation through mis-use of thin plastic film bags. And rightly so. In the majority of these cases the mothers were using the material (primarily intended for garment covers) as a makeshift mattress or pillow cover for their babies' cribs. Like so many other products of civilization, plastic bags can be a hazard as well as a boon.

The general hospital is a community health centre. It is an institution which not only looks after sick and injured, but which has a vital interest in good health in the community. The hospital participates in many ways—particularly by disseminating health facts through educational brochures, folders and lectures. What better place than the hospital is there to bring home the hazards of thin plastic film? Demonstrations given to the new mother on care of her newborn should warn of this new threat to her baby's safety.

Recently, the Ontario Safety League asked all hospitals in Ontario for their co-operation in this matter. They sent each a small brochure entitled, "Plastic Film—Correct use and Mis-use". This type of brochure, which is available from the Society, would be an excellent pamphlet to give to new mothers when they are discharged from the maternity ward.

Tuberculosis—a dying disease?

WE hope all administrators read the article, "The Present Status of Tuberculosis in Canada", by G. J. Wherrett, M.D., which appeared in the July 1959 issue of *Canadian Hospital*. Dr. Wherrett, executive secretary of the Canadian Tuberculosis Association, wrote this article especially for us. Its primary purpose was to give administrators of general hospitals an up-to-date picture of this disease.

We thank Dr. Wherrett for giving us such a complete report on a disease which has so many implications for administrators of general hospitals. Most people are too complacent about tuberculosis; it is not a disease which is dying out. "Popular optimism", says Dr. Wherrett, "is confounded by stark statistics". There have been striking advances in the fight against this disease, but we cannot sit back smugly and forget it. Progress does not mean victory. We must continue to be vigilant over prevention and control.

This article is readable as well as informative. It will be especially valuable to administrators, directors of nursing and those in charge of staff health units.

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THE tourist driving through a town is unconsciously aware of certain buildings whose architecture holds special significance. The post office and the city hall are identified with the authority of federal and local government. Types of schools show the concern of the people for education. The church spires point to the spiritual aspirations of the community. The hospital, usually a well built structure, is identified in the minds of both visitors and local residents with health in all its aspects. It is not surprising, then, that our twentieth century hospitals have gathered around themselves many activities which are related to the health of the community, but which are not primarily concerned with the art of healing.

We are all aware of the changing status of our hospitals. Not so long ago admission to hospital was viewed with serious misgivings. Infections were a real problem, surgery was a grave undertaking, and straightforward medical cases often carried a high mortality. The advent of rigid asepsis, early ambulation and the wonder drugs has reduced morbidity and mortality and has cut down the length of stay so that admission to hospital is no longer a horrifying experience. In fact, a time in hospital may be anticipated with a certain enthusiasm as a respite from the humdrum routines of domestic life. We also find that the introduction of private and government sponsored prepaid plans has encouraged people to seek admission to hospital for diagnostic and therapeutic procedures which would formerly have been handled on an out-patient basis at considerable inconvenience to the patient. This has caused long waiting lists in the admitting departments, and has made hospital administrators go grey attempting to establish suitable priorities for the reception of these patients.

Although a hospital is primarily a place for treatment of the acutely ill, we might consider just what is the corporate responsibility of the hospital towards its patients. Sometimes we think of the hospital as the doctor's workshop and to some extent this is true, but we must remember that the hospital has a soul of its own and the governing board has a definite responsibility for the quality of care provided for all of its patients.

It is a common impression that

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because a doctor holds a medical licence he will have unlimited privileges for practising his art within the hospital. On the contrary, modern medicine is highly specialized and each doctor may only undertake those procedures for which he has had adequate training and for which he has had specific approval from the governing board. It is through the well organized medical staff that the governing body receives guidance in the exercise of this authority.

Let us examine certain of the hospital activities which touch on the health program of the community.

The teaching rôle

From earliest times, health teaching and the healing arts have gone hand in hand. The temples of Asculapius provided a haven for the sick, but they were also dedicated to the discussion of all matters contributing to a sound mind and body. Hippocrates, Galen, Vesalius, and all the fathers of medicine and philosophy considered these two disciplines as inseparable. The stature of the modern hospital can be readily measured by the attention paid to the training programs which are provided for student nurses and for technicians in the various fields. Hospitals also have a responsibility for the training of practical nurses.

Teaching is a stimulus to the staff, but it is often difficult for a hospital to train a sufficient number of persons to meet the needs of its own community and to provide skilled personnel for those areas which have no training institution.

We have mentioned the well organized medical staff. Such a staff in both the large and small hospitals will be constantly stimulated by participation in clinical conferences and journal clubs, and will be kept alert through careful study of the results of treatment provided in the institution. It is essential that a doctor be critical of his own work, and be prepared to give criticism and accept it from others if he is to maintain a high level of professional competence.

A field that is too often forgotten is the responsibility of doctors and other hospital personnel to participate in community health programs. Recently there has been organized the first local Vancouver Unit of the Canadian Cancer Society. This unit is headed by a doctor who is filled with enthusiasms and the success of this new activity is assured. In the smaller community, members of hospital

The General Hospital Community Centre for Health



by

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staffs occupy positions of prestige and they have an inherent responsibility to contribute to the community welfare both in the health field and in other community activities.

Public health

Here again we must note the changing rôle of the hospital in relation to infectious diseases. Most of us can remember the time when the communicable disease ward was a thing apart. In my days as an intern it consisted of a collection of shacks at the rear of the hospital, approached through a hole in the fence. Older doctors have witnessed the decline of typhoid and diphtheria and we have reason to believe that we are seeing poliomyelitis follow a similar course. We see the Division of Tuberculosis Control embarrassed by a diminishing clientele to the point where many treatment units have had to be closed. We have also watched the development of a more tolerant attitude toward infectious disease wards in general hospitals.

In the days of Pasteur there was a theory that humours carrying disease travelled in straight lines. Our original hospital, built in 1890, took its pattern from an institution outside Paris, and was built with long curved corridors so that the germs could not get around the corners. The modern hospital recognizes that infectious and non-infectious cases can be handled in adjacent wards. At the present time we have a unit where patients with communicable disease and other medical patients are nursed from the same chart room by the same staff. When reasonable precautions are observed, there is no danger of cross-infection.

We should probably refer to the ubiquitous staphylococcus which has become the problem child among bacteria. At one time this delinquent organism had been thoroughly subdued by sanitation and by the antibiotics. Recently it has shown an intolerance for these restraints and has required strict disciplinary measures. While its presence in hospitals has been given undue publicity, there is no doubt that it can be a serious menace. In debilitated patients it has been the source of wound infection, staphylococcal pneumonias, septicaemia, and has been responsible for several deaths. We must remember that the staphylococcus is not indigenous to hos-

pitals, but that it is brought in by patients who have acquired the infection in the community. The answer to the problem in the hospital, as in the home, is strict attention to hand washing and general cleanliness.

New public health functions

A recent development in many hospitals is the inclusion of the public health officer on some branch of the medical staff. This recognizes the close association in the interests of the health department and the hospital and it provides an opportunity for close liaison on problems of mutual interest.

Two hospitals in British Columbia are co-operating with the provincial health department in providing accommodation for a branch of the division of laboratories. The province has also developed in the larger hospitals a free biopsy service. Through this service tissue specimens may be sent from doctors' offices or from the smaller hospitals to community hospitals where there is a pathologist and these specimens are examined without charge. The provincial government pays the hospital two dollars for each tissue examined.

It is quite customary for hospitals to provide accommodation for various health program activities. Where an auditorium is available this may be offered to community groups which are concerned with health problems. In our own institution we provide accommodation for one of the community well baby clinics. Because the hospital is identified with health in the minds of the public, this well baby clinic is one of the most popular in the community. A hospital may also provide a prenatal and postnatal program. It is a matter of local organization whether this will be carried out under the direct auspices of the maternity department of the hospital, the Victorian Order of Nurses, or the public health nurses.

One of the latest activities in hospitals is the development of poison control centres. Our hospital has provided the first centre of this type in British Columbia, and we have been surprised by the demands made upon it. This centre, like its counterparts in other large communities, has a fairly complete library on toxic substances and antidotes. The

Department of National Health and Welfare has provided a card file listing some 4,000 items which might be taken as poison. Although various types of acetylsalicylic acid compounds constitute the most common poisons, we have treated youngsters who have swallowed such improbable things as drain cleansers, air purifiers, and even mothballs. There is rarely a day goes by that we do not have a few telephone calls to the department from frantic mothers or requests for information from doctors.

There will be a limited number of such centres in each province, and I feel it is most important that health departments establish an easy contact between doctors and the nearest poison control centre.

Special groups

The hospital has a responsibility toward some of the special groups in the community. Throughout Canada and the United States the increasing numbers of aged and ageing persons is making new demands on our health resources. In the west this is particularly true, where in our community 17.6 per cent of the population is over 65 years of age, as against a national average of nine per cent. Before the war, our city was unique in that the death rate exceeded the birth rate and the place continued to grow. This advancing age pattern brings with it an increase in malignancy, heart disease, strokes, and the various mental changes associated with an impaired circulation.

The Canadian and American Cancer Societies have done much to assist patients with malignancy, and it seems quite appropriate that the work of these organizations should be based in the hospital. In our city, the hospital social service worker is the secretary of the local Cancer Society and the hospital telephone number is listed in the directory under the heading "Cancer Society Information Centre". Each week the chief radiologist of the hospital conducts a cancer diagnostic clinic. In British Columbia, the Order of the Eastern Star does magnificent work in providing dressings for cancer patients, many of whom have been discharged from hospital, and many of these dressings stations are based in the hospital itself. The Cancer Society assists with transportation of those patients who

must come to the hospital as out-patients for x-ray therapy.

In recent years our province has been interested in extending hospital insurance to cover patients in approved chronic hospitals. The Minister of Health has pointed out that the construction of such institutions must depend on the initiative of the local community and, in general, a community should have a population of 30,000 to 40,000 before such a chronic unit is feasible. Where a chronic hospital does exist, it is important that it operate in close relationship with an acute general hospital, so that patients may be moved freely to and from the acute hospital in accordance with the individual needs.

One of the greatest problems in our community is provision of suitable custodial care for senile patients. If hospitals are to operate effectively it is essential that they be kept clear of patients who are there simply because no other institution wishes to accept them.

Hospital based home care plans have been receiving increasing attention in recent years. The nature of such plans will depend on the local situation. In larger centres this will involve doctors and nurses from the hospital visiting certain discharged patients in their homes. Under such circumstances the quality of care must be comparable to that received by the patient while in hospital. In smaller communities this service may be limited to the provision of special equipment and sterile supplies.

Hospitals are frequently asked to lend appliances to assist in the management of patients who have been discharged to their homes. The Red Cross Society frequently operates a loan cupboard but it is advisable that hospitals be prepared to rent to patients certain specialized pieces of equipment that are not available from the Red Cross or from the appliance dealers in the community.

Any such efforts by the hospital will establish a bond of confidence with patients who may need in-patient service from time to time and will indicate that the interests of the hospital extend into the community.

Aid to the handicapped

Let us think now of the groups of handicapped patients in the community. The Canadian Arthritis and Rheumatism Society is providing a splendid service for patients with joint and muscle

disabilities. It is reasonable for this organization to work closely with the physiotherapy departments of the local hospitals, and in our community the C.A.R.S. headquarters is in one of our hospitals. When poliomyelitis was epidemic our hospitals maintained an out-patient clinic for post-polio patients, giving them support after they had been discharged to their own homes. The physiotherapy departments provide a similar service for post-traumatic cases, frequently under the auspices of the Workmen's Compensation Board.

Recently there has been increasing interest in the care of children with cerebral palsy. In our hospital we have devoted a large area to the Cerebral Palsy Association where these children receive physiotherapy, occupational therapy, speech therapy, and schooling. They are brought to and from the hospital in "Bunny Buses" driven by off-duty firemen. Classroom work in the hospital is directed by a teacher provided by the school board with many voluntary assistants. I feel that there is a great sense of security and satisfaction to parents when such a unit is operating in conjunction with a hospital and under the general supervision of the medical staff. (See *Canadian Hospital*, December 1958, page 33)

Our hospital has recently introduced a program for training diabetic patients. A half-time nurse has been appointed, whose sole duty is to give instructions to diabetics before they leave the hospital and to hold regular meetings with them in the hospital after they have returned to their homes.

When we think of the health rôle of hospitals we must look with appreciation to the assistance given by our governments. In British Columbia the provincial government contributes 50 per cent of the cost of new construction, and the federal government has recently increased its contribution toward building costs to \$2,000 per bed. The provincial government also provides a third of the cost of new equipment. Certain major items of equipment used by the hospitals are provided by the provincial government on a loan basis, at no cost to the hospital.

One should also mention the great assistance to hospitals provided by the government hospital insurance services. Before the ad-

vent of hospital insurance it was necessary for us to go hat in hand from one municipality to another at the end of each year, pleading for grants to make up hospital deficits. The introduction of government insurance has not removed all our financial worries, but it has meant that our financial relationships are chiefly with the one organization, and the assistance given by the government has greatly relieved the pressure on the hospitals. At the same time it must be remembered that the government is not a fairy godfather with unlimited resources, and it is the responsibility of the hospital to keep expenses within reasonable bounds. We feel quite strongly that any government sponsored pre-payment plan should carry with it a fairly substantial co-insurance for each patient, if unreasonable use of the hospitals is to be avoided.

Future relationships

Let us look now into the crystal ball and see what the future holds for the hospital in its community health rôle. The introduction of the federal Hospital Insurance and Diagnostic Services Act has laid the foundation for a broad acute and chronic care program as soon as the necessary arrangements can be worked out with the individual provinces. Our provincial chronic care program is on the statutes, and will be implemented as soon as a sufficient number of communities have provided suitable chronic hospitals.

We are seeing an increasing tendency to handle communicable diseases and mental health problems in the local hospital rather than referring these patients to outside institutions. We see an increasing number of groups organized to assist the patient with certain specific diseases, such as cancer, heart disease, multiple sclerosis, diabetes and cerebral palsy, and we have seen the government undertaking treatment of tuberculosis and venereal disease. Although the family doctor sometimes wonders if he is losing control of his patients, these groups are here to stay and we will probably see a further organization of public interest in relation to other types of illness. It is essential that the hospital make every provision for co-operation with these groups, for after all we have one common concern—the health and welfare of every member of the community. ■

Provision for Long-term Patients

WHEN a plan for hospital insurance in Canada was developed, the need for including provisions for convalescent persons or those suffering from chronic illness requiring hospital care was early recognized. This inclusion was based on the fact that many people do suffer from long-term illness for which hospital care is needed; and that very few pre-paid hospital insurance plans have provided anything more than very limited coverage for these types of illness. Another important fact was that hospital facilities for convalescent and chronic care can be constructed and operated at considerably less cost than those needed for active treatment.

The inclusion of convalescent and chronic care in the hospital insurance plan has raised several problems which have had careful study and attention in Ontario. Two of these problems can be discussed under the following headings.

Definitions

An effort has been made to define the meanings of certain terms which are used rather freely. The Hospital Insurance Plan in Ontario provides payment for care in hospital of all insured persons for as long as it is "medically necessary" for the following types of illness or disability:

Acute Illness or Injury

These are patients who are cared for in the active treatment hospitals and whose admitting illness or injury requires only a limited period of time in hospital—usually about seven to ten days.

Convalescent

These are patients who have

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Toronto, Ont.

had an acute illness or injury and who require a period of convalescence, of long or short duration, to recover sufficiently to leave hospital. The convalescent patient is the one who usually requires physical rehabilitation.

Chronic

These are patients who, as the result of illness or injury, have a permanent physical disability which requires continuing treatment, skilled nursing care, and special services; and who cannot receive the care they need outside a hospital.

With these three types hospital care is essential. In other words, there is a medical reason for the patient's being in hospital.

Chronic vs Domiciliary

Because of the longer life span, there are increasing numbers of elderly persons who, because of infirmity, senility, or physical

disability, are unable to care for themselves. Their needs are purely custodial or domiciliary, because they require suitable accommodation, food and varying measures of assistance in looking after themselves. Many of these people have received care in hospital and remain in hospital although they do not require continuing hospital care.

The identification of the truly chronic patient is the responsibility of the physician. In making the identification, the physician often has a difficult decision because he is concerned about where the patient can find suitable accommodation outside the hospital. There is often an economic problem and many elderly people and their families are convinced that once an elderly person becomes unable to look after himself, he should be cared for in a hospital.

This is the major problem—the identification of persons requiring chronic care who are the financial responsibility of the insurance plan, and the persons requiring merely custodial or domiciliary care who cannot be the financial responsibility of the plan.

Existing Facilities

Hospitals for the Chronically Ill

These hospitals are set up and operated for the care of those with a chronic illness. There are 15 of these hospitals providing a total of 3,148 beds.

Chronic Care Wings of General Hospitals

There are 24 general hospitals in Ontario which operate chronic care wings. These each vary from eight to 110 beds, and provide a total of 1,110 beds.

Private Hospitals

There are 24 of these hospitals also in Ontario which have been licensed and approved under the Private Hospitals Act of Ontario, 1957. They have a total of 500 beds.

The total number of beds available for chronic care, then, is 4,758, or about 0.8 beds per 1,000 of population.

All of these chronic care hospitals have been visited, and it is apparent that many of their patients are of a custodial or domiciliary type. The hospitals and their medical staffs state that in many instances the patient does not need hospital care, but that there is no satisfactory accommodation outside hospitals where he may go.



J. B. Neilson, M.D.

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Quite a few active treatment hospitals in Ontario have numbers of chronically ill and custodial patients, for whom no other suitable accommodation exists. This is particularly noticeable in the smaller hospitals and in some instances results in long-stay patients who no longer require hospitalization occupying beds and excluding active treatment patients needing hospital admission.

A report form, completed by a physician, is required on all patients who remain in hospital more than 30 days. This procedure is designed to keep long-stay patients under regular review, to give a continuing picture of the long-stay problem and to permit identification of the chronically ill or custodial patient.

Many applications have been received from nursing homes throughout Ontario requesting approval as private hospitals for the provision of chronic care. Approximately 150 of these nursing homes have been visited and examined. The chief conclusion reached from these visits is that very few nursing homes can meet acceptable hospital standards and that the great majority of their patients (at least 80 per cent) are custodial or domiciliary.

Numerous discussions have been held with public welfare officials on the common problem of custodial care. It is apparent that identical views are shared by officials of the hospital insurance plan and of public welfare on what constitutes a custodial or domiciliary person. In Ontario, with the encouragement and support of the provincial Department of Public Welfare, development of bed care units in homes for the aged has reached the point where about 25 per cent of accommodation in these homes is now available for elderly inmates who, because of an infirmity or disability, are required to spend all or part of each day in bed. These people are not chronically ill within our definition.

A major study has been carried out by the staff of the Research and Statistics Division of the Ontario Hospital Services Commission on the chronic bed needs by counties in the province. This study brought out the following:

(a) That the chronic bed need is about one bed per 1,000 of population, although this figure will need to be raised to account for the percentage of population over

65 years of age in the area under consideration.

(b) That where a shortage of chronic beds exists hospitals are having problems in clearing long-stay cases, but the most serious hospital clearing problems are occurring where an acute custodial bed shortage exists, whether there is a shortage of chronic beds or not.

(c) That where a shortage of custodial beds exists, there is a "backing up" of custodial patients into chronic and active treatment hospital beds.

(d) That where shortages of chronic care beds and custodial beds exist, much of the shortage is being met by nursing homes.

(e) That where no shortage of active treatment or chronic care beds exists, on the basis of statistical evidence, but where a shortage of domiciliary facilities does exist, acute over-crowding in hospitals is occurring.

Conclusions

A properly balanced hospital system requires sufficient active treatment beds, chronic and convalescent beds, and adequate welfare accommodation for domiciliary patients. A shortage of chronic beds reflects on the proper use of active treatment beds, and a shortage of domiciliary beds reflects on the proper use of chronic care and active treatment beds.

A serious shortage of chronic care beds exists in certain parts of the province, and the communities must be made aware of their responsibility to develop these needed beds.

Domiciliary accommodation is lacking too in several parts of the province and every possible method should be used to encourage municipalities to develop or expand existing homes for the aged, and to provide bed care in these institutions.

Attention may now be turned to what is being done, or planned, in the province to meet the need for chronic and convalescent care beds.

No accurate estimate has been made on the number of convalescent care beds required as yet, and little detailed study has been made, because of the precedence of the chronic care problem. However, it is held that one-half bed per 1,000 of population would meet the need for this type of accommodation, provided that recognition is given to its chief

function; namely, physical rehabilitation. On this basis of estimated need, the provincial requirement is 2,950 beds, of which only 455 are available. However, several hospitals in large centres have enough beds and facilities to carry out a convalescent care and rehabilitation function.

The problem here calls for careful planning of proper rehabilitation units at strategic locations, so that the staff available to work in these units may be conserved. Careful attention must be given to the degree of out-patient function of these units. The importance of convalescent-rehabilitation hospitals to a hospital insurance plan lies in the facilities they make available for medical assessment of disabilities and their rôle in physical rehabilitation. All these are part of the broad program of proper use of hospital beds.

In providing hospital facilities for chronic care, the figure of one bed per 1,000 population has been used. This makes a chronic bed need at the present time of 5,900 beds, and a shortage of approximately 1,150 beds. Since the population is continuing to grow, an annual need for between 180 and 200 beds will have to be met.

The Commission is satisfied that the proper development of a hospital system cannot include the use, on a long-term basis, of proprietary or private hospitals. Accordingly, where a definite shortage of chronic beds exists, effort is being made to interest the community in developing building programs to provide chronic care facilities. One answer to the chronic care problem could be the development of large chronic hospitals at designated locations throughout the province. This arrangement would permit more careful control of admissions and setting up of treatment patterns, and probably would be the best method economically. However, this plan would require the transfer of many elderly, chronically ill patients from their own community to these large hospitals which might be miles away.

The present policy is one of attempting to develop chronic care wings of existing general hospitals and the expansion of existing hospitals for the chronically ill. Encouraging success has accompanied a rather strenuous effort to do this. We now have the following number of beds for the chronically ill:

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|---|--------------|
| Added since 1 January 1959 | 226 |
| Soon to be added | 30 |
| Soon to be converted to chronic use | 107 |
| Chronic beds under construction | 372 |
| Final plans approved for chronic bed construction | 808 |
| Total | 1,543 |

It is apparent that, based on present calculations, the need for chronic beds will be met adequately within the next two years.

One of the factors stimulating the development of chronic care facilities is the provision of capital construction grants. In Ontario, at present, \$2,000 per bed is available from the federal government, and \$3,000 per bed from the provincial government, plus other lesser grants for ancillary areas in the hospital. Careful attention to the planning of chronic care hospitals is producing adequate buildings and facilities at prices not too greatly removed from the grant monies available. For example, an 800-bed chronic care hospital planned in Toronto is

expected to be built and furnished for approximately \$7,500 per bed.

More readily available hospital facilities which lend themselves to chronic patient care are those in the sanatoria for tuberculosis patients. As of May 1, 1959, a total of 15 of these sanatoria in Ontario had 3,850 beds. Of these 1,120 beds (or 29 per cent) were vacant. Of the vacant beds available in sanatoria 245 have been converted to chronic care and 50 more are being considered for similar use.

Unlimited use of empty beds in sanatoria is not possible, however, since many of the beds are in buildings which were designed when rest in bed in well-ventilated rooms was the accepted treatment for tuberculosis. Many of the buildings are inadequately supplied with the usual hospital services and, in many instances, the age and construction of the building, with its fire hazards, make it an uneconomical renovation project. Another problem is that some sanatoria are in remote areas, or in an area where enough chronic beds exist. However, it is planned to make

as many beds in sanatoria available for chronic care as statistical studies indicate are needed.

A much more difficult problem crops up when the possibility of using nursing homes to provide care for chronically ill patients is considered. It has been pointed out that some 500 beds in private hospitals in Ontario are approved for the provision of chronic care. These institutions were originally nursing homes which have met the provincial standards required for licensing as a private hospital, and the beds they make available are a great help.

Some of the difficulties encountered in using nursing homes have appeared in the surveys of these homes. As pointed out previously, they are giving care mostly to domiciliary patients and few of them can meet the acceptable standards of quality of patient care, availability of treatment facilities, absence of fire hazards, and freedom from overcrowding of patients. Most nursing homes have been established in large houses, many of which cannot be

(concluded on page 74)

Students in Hospital Administration, University of Montreal



Shown here are the students and members of the staff, Institut Supérieur d'Administration Hospitalière, University of Montreal, Montreal, Que. The students are now ready for administrative residencies in hospitals in Canada and the United States.

Front row, (l. to r.): Michel Dubreuil who will go to Hôpital Ste-Jeanne d'Arc, Montreal, Que. under the preceptorship of Albert Nantel; Albert Nantel, professor of business administration; Dr. Gerald LaSalle, director; Mother Jeanne-Mance, R.H.S.J., assistant director; Leo Dorais, professor in human relations; and John H. Poupart, who will go to St. Mary's Memorial Hospital of Montreal, under Sr. Melanie, S.P.

Second row, (l. to r.): Archie Deskin who will go to the Jewish General Hospital, Montreal, Que., under Samuel Cohen; Yves André, to the St. Vincent Hospital, Worcester, Mass. under Mother M. Loreto; Madeleine Coté, to the Royal Victoria Hospital, Montreal, under Dr. Gilbert Turner; André Despatis, M.D., to Hôpital Notre Dame, Montreal, under Dr. Paul Bourgeois; Sr. Liliane Pelouin, to the Good Samaritan Hospital, Dayton, Ohio, under Sr. Marie Charles, S.C.; Guy Saint-Onge, to Hôpital Ste-Justine, Montreal, under Mme L. de G. Beaubien and Sr. Noemi de Montfort; and Alfred Boisvert whose destination has not yet been determined.

THE subject of progressive care is a timely one and the wide interest shown in it is indicative of the eagerness with which the hospital field is seeking practical solutions to the problems of providing better hospital care.

Progressive patient care is a term which has come into use to describe an arrangement whereby patients may be moved from an intensive care unit to an intermediate or ordinary type of accommodation and then, before discharge, to a convalescent or self-help type of accommodation. Much has been written and said on this subject. Now we have home care and, if needed, admission to a long-stay unit added to the sequence. Like so many changing concepts, it has its enthusiasts and its doubters.

In appraising this development, we must keep certain basic concepts in mind:

1. The shortage of trained personnel, particularly of qualified nurses, is bound to increase as we get more hospitals with more beds, have a shorter work week with continuing round-the-clock operation and as the staff tend to drift towards less exacting and more remunerative work in industry and in government.

2. We cannot hope to continue as in the past: We must devise some means of providing care which will permit more patients to be looked after by fewer people.

3. The hospital picture is changing more rapidly than many of us realize, perhaps because changes have been gradual over the years. We must be prepared, as times change, to discard the old if the new methods can prove themselves.

4. From the viewpoint of the hospital, any proposed major revision in planning and procedure must prove that: (a) it adds to the efficiency of care; and/or (b) it really saves personnel and can be reflected in lower operating costs; and (c) it is acceptable to the patients, the doctors, and the hospital personnel.

5. It should be applicable to a given hospital without extensive changes in the existing plant and without upsetting its continuing service to the public.

6. It should fit into the trend to-

Dr. Agnew is professor of hospital administration, University of Toronto, and partner in the hospital consulting firm of Agnew, Peckham and Associates. He gave this address at a Symposium on Progressive Care to the Philadelphia Hospital Association, Philadelphia, Pa., earlier in the year.

Progressive Patient Care

G. Harvey Agnew,
M.D., LL.D., F.A.C.P., F.A.C.H.A.,
Toronto, Ont.

wards greater integration of the hospitals with each other and with the general health and welfare programs of their communities.

Intensive Care Unit

Few people, if any, would deny the value to the seriously ill patient of an intensive care unit, sometimes known as a "critical care" unit or a "maximum care" unit. There may still be some question about relative over-all costs and of certain administrative problems that arise, but not of its clinical benefits.

A major question in the minds of administrators or trustees is whether it would work in their own hospitals. If so, how big should it be, and how set up? Who should be kept there? And the big question—will we lose revenue?

We have found considerable difference in viewpoints. Some would keep it quite small—eight to 12 beds for a 200-bed hospital; others would provide 25-30 beds for such a hospital. We note that several writers say ten per cent and higher; a U.S. public health service authority says four to five per cent. Some would admit only surgical patients; others medical and surgical. In one new 400-bed hospital, in which we are interested, the medical staff has asked for two intensive care units—one for surgical and the other for medical patients. It was the opinion of the doctors that the nurses could be more efficient by specializing, and that pneumonias or other acute infections should not be on the same ward with surgical cases.

For smaller hospitals (up to 75-100 beds) it has seemed advisable

to have a small well-equipped unit as part of a larger ward, either at one end or adjacent to the nurses' station. It should, of course, have full equipment, have its own nurses' sub-station, medication area and utilities if it is at the end of a ward or separate.

In planning, ready visibility is highly important. The trend would seem to be in favour of open wards of four to six, with a few single rooms for isolation, quietness, or other purposes. Some find a few two-bed rooms useful, though less conducive to group care.

We know that in quite a few intensive care units as now set up men and women share the same room, but, contrary to the opinions of some, we believe this arrangement should be for unconscious patients only, as in a post-anaesthetic room. Many men and women would burst rather than use a bedpan with a member of the opposite sex on the other side of a thin, cotton curtain. We are still concerned, too, about the effect on a seriously ill, frail and apprehensive woman if a burly and delirious ex-wrestler in the next bed started to take the bed apart. For a comparable reason we cannot agree with some commentators that psychotic patients could be admitted here in the absence of a psychiatric ward. No patient should be disturbed or have his chances of recovery impaired by another.

We have been impressed by the circular units developed in a small hospital at Brookhaven, L.I., where one- to four-bed rooms surround a central nurses' station. This type of construction would lend itself well to intensive care, for it should provide good oversight, a shortened nurse mileage and privacy and quietness when needed.

Obstetrics

On the obstetrical service the problem is whether to move critically ill patients into an intensive care unit or leave them on the obstetrical floor. Large hospitals with a heavy maternity service might consider an intensive care unit for obstetrics alone, but we believe that this would be rarely needed. It would seem better to leave such patients on the maternity nursing floor—possibly in a small unit of four to six beds fully equipped and staffed for their needs. There is always the danger of infecting maternity patients by mixing them with surgical and medical patients; an exception may be a caesarean case, particularly if the operation is done

in the surgical suite, and there is a surgical "intensive care unit."

Of most value on obstetrics, in our opinion, would be a proper recovery or post-anaesthetic room where the patient could rest for a few hours post-partum to ensure a hard fundus and cardiac recovery. If the patient continues to be weak, or has a severe hemorrhage, a well-equipped room, close to the nurses' station, would be preferable. If she develops severe pelvic infection or other serious complications, she might then be taken to the intensive care unit for special attention.

For a convalescent unit on obstetrics, we cannot see much practical value. The stay is so short these days that patients are seldom in long enough to warrant such a service. A determining factor, too, is the newborn infant. If we had intensive care, intermediate and convalescent units, all on obstetrics, we would need either (a) to carry the infants longer distances from the nursery to the three patients' units, or (b) to provide three sets of nurseries, which, to quote Euclid from our geometry books of school-day memory, "would be absurd". One could, of course, have an up-patient dining area, perhaps a part of the solarium set-up.

Children's unit

For the children's service we would have some reservations about progressive patient care. Naturally, a large children's hospital could have an intensive care unit with much benefit. However, for most general hospitals with a limited children's service, it would seem better to us to keep the critically ill children on the children's floor where the nurses are trained in caring for children and where the special equipment for children is kept. Certain rooms could be especially equipped for emergencies, rooms close to the nurses' station, and these could have special staffing when necessary.

Other factors supporting such a policy would be the wide variation in the daily and seasonal use of the children's service, and also the changing demand from day-to-day for bassinets, cribs and youths' beds. Nevertheless, if the children's service is small and not adequately staffed, we would not hesitate to recommend that older children in particular be taken to the intensive care unit.

For administrative consideration

Several factors in administration need to be considered. For instance,

will patients be admitted directly on instructions from the physician or the admitting officer, or must they first go to an ordinary or intermediate ward and then be transferred, if considered advisable? Such procedure, favoured by some, may have serious results for a patient bleeding internally, or in shock. Some flexibility is desirable.

Some hospitals limit visiting severely and some only slightly. Unless fairly strict limitations are imposed, visitors can interfere with proper treatment and, in multiple bed rooms, can seriously disturb other patients. Yet, too strict limitations where patients are critically ill may affect public relations unless the situation is tactfully handled. This is an argument against having too many in one room.

As the time of transfer to the ordinary or intermediate unit depends on the patient's improvement, there naturally follows uncertainty (until proper notification of transfer has been circulated) as to where to direct visitors, send up drugs, special diets, flowers, mail and telegrams. This puts an onus on the administration to develop a system of prompt and widespread notification to certain departments, with constant checking of lists by information clerks, dietitians, technicians, messengers, and others. Public relations could suffer unless this is carefully watched. What should be done when flowers arrive early and flowers are not permitted in the intensive care unit?

If a special rate for extra nursing and other care is set up, this must be "sold" to the patients, to Blue Cross, compensation boards and other bodies meeting the charges, and, in Canada, to hospital insurance commissioners. This should be possible, but it may take a bit of doing in some instances.

The administrator may not be able to tell for some time whether or not his extra costs will be balanced by what he can gain by added revenue on the intensive care unit and what he can save by reduced staff elsewhere. All too frequently it is difficult to have reduced work on the other services reflected in the payroll. In this instance it is the patient who saves by having his special nurses replaced by a modern version of the "group nursing" procedure developed in the lean 30's. Too, the administrator will need to decide whether or not to "hold" a room for a surgical patient during the two or three days he is first in

post-anaesthesia and then in intensive care; if so, would he be charged, as he should be, for both accommodations? Generally speaking, rooms are not so held and he is charged for one bed only—in the I.C.U.

If only the very acutely ill are placed in the intensive care unit and they are routinely transferred to the intermediate or ordinary wards as soon as they are over the worst, the problem of longer stay does not arise. But if, as in one such unit which is set up more like an ordinary well-equipped nursing unit, there is a tendency to let patients likely to go home in a few days stay there until they are discharged, the unit must be large enough to permit the longer stay.

Some doctors would prefer this arrangement, as would also many patients. This would happen more often if the set-up were similar to the usual one—single, two- or four-bed rooms; remaining on would not likely be desired if an open ward arrangement more like a post-anaesthetic room were set up. In one particular hospital (the new 240-bed Greater Niagara General Hospital) a 58-bed, double corridor floor is set aside for acutely ill medical and surgical patients, arranged as two 29-bed units. Mostly in two-bed rooms, it is not laid out in the open, cubicle ward style favoured by some people but is planned to permit a more quiet atmosphere and more privacy, although, admittedly, nursing is less economical than in an open ward. Here, patients are not necessarily transferred as soon as the acute stage is over, but may stay on, depending on the pressure for beds. With this arrangement, the tendency to develop an undesirable "musical chairs" procedure is minimized; we like this.

What should hospitals do about this trend?

For large hospitals one would definitely favour an intensive unit—possibly more than one. For medium sized hospitals (150-250 beds) we would favour a modest sized unit of six to ten per cent of the total surgical and medical beds, the number depending on the surgical load, the proportion of long-stay patients, and other factors. We are dubious about large open wards, especially if the community is one where privacy is appreciated.

For hospitals of smaller capacity, under 100 or 150 beds, there could

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UNIONS AND YOU

EVERYONE employed in a hospital should be working to improve patient care. If a hospital worker is not interested in promoting good patient care, he should not be in the hospital.

This simple, general philosophy applies to any organization. A person should not work at any job—teaching, manufacturing, business, selling or hospital care—if he does not believe in his product or service and in the objectives of his work. It is true that this ideal situation cannot always be attained. Frequently, a worker must take a job in order to provide for his family and himself, even though this may not be a job for which he is particularly suited. Even so, the worker should be able to identify himself with the objectives of the organization for which he toils. If he cannot do this, he should seek employment in a field where the objectives do appeal to him.

It is my belief that any organization of workers, whether it be a trade association, a professional society or a union, must recognize its share of responsibility to foster and to promote the objectives of an enterprise as a whole. "A good day's work for a good day's pay", is a phrase that carries much meaning. Until fairly recently, union organizations placed most emphasis on good pay and not enough on good work. During the last few years, there is evidence that responsible unions are increasingly accepting responsibility for encouraging good work as well as good pay.

Unions first made their appearance on this continent in the late 1700's and early 1800's.* These original groups of workers were mainly small, local trade associations or trade unions. One of the first large labour groups was the

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Saskatoon, Sask.

Noble Order of the Knights of Labour, which was established in 1871. This society was, at first, a secret order but the secrecy was later abandoned. A militant group, the Noble Order of the Knights of Labour sponsored strikes, unrest and political agitation in order to gain their ends. Around the turn of the century, the Knights of Labour numbered 700,000 members.

The Industrial Workers of the World, commonly known as the I.W.W., and often scathingly referred to as the "I won't works", first became prominent about 1905. This relatively large federation of workers also advocated direct action in order to gain their ends and, as a result, fostered many strikes and much labour trouble. Some segments of the I.W.W. placed their ideology before loyalty to their country during the first world war. Thus, while many of their members were undoubtedly honest trade unionists, the actions of the more radical segments eventually made the organization extremely unpopular, and by the 1920's it had practically ceased to exist.

During the period of the rise and fall of the Knights of Labour and of the I.W.W., other trade unions were growing slowly and steadily. Although the numbers of members still remained small, the advance of many of these other groups was reasonable, ethical and progressive. However, the actions of less responsible groups were so provoking to the average citizen and so newsworthy that most people associated union activity with bloodshed, strikes, bitterness, and opposition not only to management, but also to the public good.

One of the labour organizations which developed more slowly and with much less fanfare was the AF of L, the American Federation of Labour, which was founded in 1886. This was a federation of various trade and craft unions as well as industrial unions. In 1935

the C.I.O., the Congress of Industrial Organizations, was formed, partially by independent organizers and partially by members of a dissident political action group of the AF of L. The C.I.O. was mainly a congress, or federation, of industrial unions and, from the beginning, was a militant, mass-organizing group. The period of its formation marks the beginning of the rapid increase in size of the labour unions. In 1933, there were still only approximately three million union members in the United States and by 1946 there were something more than 15 million trade unionists. Today there are between 17 and 18 million trade unionists in the United States and one and one-quarter million in Canada.

Although many unions have long endorsed proper training and education of their members, the development of highly skilled workers among their ranks, a healthy interest in good management, and stimulation of their members towards the objectives of the enterprises for which they work, it has not always been so. Even recently, we have only to recall the publicity which accompanies scandals in union organizations to know that all is not sweetness and light. In addition, most of us have grown up in a period when the machinations of I.W.W. and similar groups remain relatively fresh in our memory. Fortunately, the majority of trade unionists have turned their backs on the unpleasant methods of the past and on the corruption that exists in some today. Unfortunately, most of us still think of unions in terms of what the radicals did, not many years ago, and what some of the unscrupulous still do today. The administrator's rôle in working with unions to improve patient care in the hospital is thus more difficult than it might otherwise be.

Seven Administrative Activities

1. The administrator should recognize that unions are here to stay. They are no longer small, independent groups, but number their members in the millions and are highly organized, allied groups led by trained, educated, and often brilliant, men. If the administrator and his board do not want a union in the hospital, they cannot dispell it as a bad dream. If the employees want union organization and a union is interested in serving these

(concluded on page 64)

Dr. Swanson, who is executive director of the University Hospital, Saskatoon, Sask., gave this address at the Saskatchewan Hospital Association convention in October 1958. "Personnel Management" by Scott, Clothier and Sprigal. Published by McGraw Hill Book Company, Toronto. Page 539.



—B.C. Government Photograph

Lillooet

NO longer do Lillooet citizens have to be rushed to Kamloops or Vancouver when they suffer multiple fractures or when they need x-ray examinations. The new Lillooet District Hospital, nestling among the mountains of British Columbia, will look after them now. It was officially opened in May 1959.

A building to be proud of (and the citizens are proud), the hospital is a one-storey, reinforced concrete structure, completely fireproof and providing accommodation for 16 beds and 8 basins. Designed by Alan Gray,

M. A. Stilwell and William Lobban of Vancouver, the hospital was built in the form of a modified "T". An additional storey will be added in the future and four beds in an unfinished area can be brought quickly into use.

The hospital provides such necessary services as operating rooms, maternity ward and laboratory. There is also a new, up-to-date nurses' residence with 10 beds. The total cost of this ambitious project was estimated at \$392,500. But its worth to the citizens of the town can never be measured in dollars. ■

Neils Harbour

OFF the Cabot Trail in Cape Breton Island, in the isolated little fishing village of Neils Harbour, stands another small hospital built by the Red Cross Society and the determination of the hardy residents of this mountainous section of Nova Scotia. Neils Harbour's first year-round hospital services came in 1946, when the Red Cross converted the old Buchanan homestead to hold 12 hospital beds. All sterilizing and autoclaving had to be done in the kitchen oven or pressure cooker (no electricity until 1951), and it wasn't until 1952 that a telephone line was put in. But all that is past now; and after seven years of undaunted planning and fund raising—even special herring catches were sold



—Photograph by Hal

for hospital funds—a new building, costing \$120,000 was opened in November 1953.

The picturesque Buchanan Memorial Hospital shown here, designed by architects Leslie R. Fairn of Halifax and Wolfville, N.S., has 17 beds (three are bas-

sinets) and all the modern facilities necessary for a hospital of its size. It was furnished and administered, of course, by the Red Cross Society, who have only this year transferred the ownership of the hospital to the people of the community. ■

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From
Newfoundland

to

British Columbia



AN up-and-coming young hospital is that built in 1957 at Carbeneer—the first Red Cross Hospital to be opened in Newfoundland. It took the Red Cross Society, the government and the residents of this little town on the east coast of Conception Bay, who with their neighbours make up the Carbeneer Medical District, less than two years to organize, build and complete the neat brick-faced building pictured here. On December 31, 1958 the Red Cross Society relinquished the hospital to the community to run on its own.

The two-storey hospital acts primarily as an emergency centre, and it is equipped and organized

as such. It houses 18 beds, five cots and nine bassinets, as well as an x-ray clinic and laboratory, delivery room, sterilizing room, and kitchen, to care for maternity and medical cases. No elective surgery takes place, but the hospital does have an operating room to meet the emergency cases.

Living quarters for staff are found on the second floor. Also included on the ground floor are a well-baby clinic, a dental clinic and a small laundry. A neat white picket fence surrounds the hospital property, and the superintendent and doctor can put their cars in the three-car garage provided especially for them, along with the ambulance. ■



—B.C. Government Photograph

Burnaby General Expands

A NEW \$1,550,000 wing at the General Hospital in Burnaby, British Columbia, completed and opened in May 1959, marks off the second phase of a comprehensive building program planned by this west coast hospital. The sleek-lined, modern five-storey addition more than doubles the size of the hospital by providing 123 more beds. This brings Burnaby's bed capacity up to 244 beds and 69 bassinets—an impressive step on the way to their objective of reaching an eventual total of 600 beds. Architects are: Gardiner, Thornton, and Gathe.

On the ground floor of the new wing are areas for emergency treatment, physiotherapy and laboratories. Patients are cared for on the second and fifth floors, the operating theatres are on the third and maternity wards and nurseries take up the fourth. ■

Evaluating Schools of Nursing

FIFTEEN years ago, in 1944, at the Canadian Nurses' Association's biennial meeting, a panel of members recommended national accreditation as one means of assisting schools of nursing to reach their objective — preparing nurses to meet the needs of the Canadian people.

In 1945, the C.N.A. executive committee approved the principles of accreditation and asked the committee on nursing education to initiate a plan of action as quickly as possible. From that time until 1956 interest was maintained but other programs had priority, and funds were not available. At the General Meeting of the Canadian Nurses' Association in 1956 the association approved a resolution to study all aspects of an accreditation program. The funds for the project were obtained mainly through contributions from the Canadian Nurses' Association and the provincial nurses' associations. This decision, made after considerable study, was motivated by the belief that if the quality of nursing service rendered by the profession were to be improved, then preparation for that service *must* be improved.

It was also recognized that the nursing profession, like any other profession, had the responsibility for evaluating its own program of education. Following the General Meeting, the objectives and a plan of action for a Pilot Project for Evaluation of Schools of Nursing were formulated by the Special Committee.

The objectives of the Pilot Project were stated as:

1. To determine whether Canadian Schools of Nursing are ready for a program of accreditation and, if it is feasible at this time, to initiate a program of accreditation.
2. To determine the basis on

Miss Mussallem, who is director of the pilot project for the Canadian Nurses' Association, gave this address at the Maritime Hospital Association's convention in May 1959.

**Helen K. Mussallem,
B.N., M.A.,
Ottawa, Ont.**

which schools of nursing in Canada can be accredited.

3. To explore procedures in carrying out an accreditation program.

4. To determine the personnel and other resources needed to carry out a national program.

5. To estimate the cost of a national program of accreditation.

6. To acquaint the Canadian people with the needs of nursing.

In order to involve in this study hospital schools of nursing in as many regions of Canada as possible, the 174 diploma or hospital schools were asked to indicate their willingness to participate. Ninety-six schools volunteered, and from this group the Special Committee selected 25 according to geographical location, size, control and type of program. At least one school in each province was chosen. Two were selected from each of the four western provinces, five from Ontario, seven from Quebec (five French language schools and two English language schools) and five from the Atlantic provinces. The selection of school in relation to size, control and type of program was also made in relation to the total group of schools. The committee also selected ten regional visitors to participate in the surveys of the schools. The visitors are directors of nursing, or nursing education, from a province adjacent to the one being visited.

A director for the study was appointed in September 1957. In preparation for the Pilot Project the director worked with the National League for Nursing Accreditation Service for four months, studying the philosophy and procedure of their program with a view to adapting these methods in the survey of selected schools of nursing in Canada. This orientation included participation in accreditation visits in widely distributed geographical areas in the United States. It was

a most interesting and stimulating experience, and one could not help but be impressed by the dynamic nature of their program.

The policies, criteria and procedures followed in this accreditation program in nursing are based on principles widely accepted and tested in education for the other professions, and in general education.

Accreditation in nursing is more than an evaluation. It is a program in which the educational units themselves play a vital part. It aims to help schools in their efforts to improve the nursing program they offer by providing them with assistance in the continuous process of self-evaluation. Many would agree that voluntary accreditation is one of the most effective means available for encouraging schools of nursing to improve their programs.

The Pilot Project for Schools of Nursing in Canada has been divided into three major phases: (a) a preliminary visit to all 25 schools for interpretation; (b) a one-week survey to all selected schools; and (c) evaluation of the survey and the final report.

In initiating the first phase of the Pilot Project, a one-day visit was made to the schools in all provinces in order to acquaint the faculty and administration of schools of nursing with the survey procedures and to explain the types of supplementary data required. Activities carried on during the preliminary visits and during the surveys of schools included conferences with provincial deputy ministers of health, when feasible, with the national executive directors of the C.H.A., C.M.A., C.P.H.A., C.A.A.E.* and other professional groups with the national deputy minister of health, and other national, provincial and local people. There were also interviews with members of the press, radio and television.

During the past year, orientation conferences were conducted for both regional visitors and the board of review. The board of review, whose responsibility is to pass judgment on the programs surveyed, consists of eight nurses, representing all regions in Canada, who are actively engaged in nursing service and nursing education, as well as one representative from the C.H.A. and one from the C.M.A.

The second phase of the project has also been completed. A one-week survey visit has been made to all 25 schools by the director and one

*Canadian Association for Adult Education

of the regional visitors. In the French language schools, there were three members on the fact-finding survey team. In addition to the other two members, there was a senior bilingual evaluator, and the report was written in both French and English.

There is much that could be noted here about our visit to the schools. Each visit was a stimulating and exciting experience for the visitors. Extensive preparations were made by the schools involved. Prior to the survey, each school selected completed a detailed preliminary information schedule, answering questions on all aspects of the educational program, as well as submitting supplementary current materials. During the survey, many schools commented that even the initial step of completing the questionnaire had assisted them in self-evaluation and improvement.

When the survey was scheduled, the visitors spent one week at the school. The visit provided an opportunity to verify, document and clarify the information submitted in the written materials. Every effort was made to help the faculty see the relationship of this visit to the total project — a process through which it can develop skills in evaluating its own program, in identifying its problems, and in seeking solutions for these problems.

The survey team spent the first day of the survey reviewing all the written materials; the second, third and fourth days visiting in the school; and two days writing the report which was read to the faculty before the visitors left. The visit in the school included conferences with the administrator, the director of the school of nursing, the director of nursing service, all faculty members, supervisors and head nurses, librarian, student counsellors, residence director, social director, director of the health program, representatives of the co-operating teaching agencies, student representatives of each class, and the student organization, as well as any other individuals or groups who contribute to the educational program.

Tours were made through all departments of the hospital where students receive experience, the school of nursing, students' residence, health offices, and library. Visits were made to one of the co-operating teaching agencies, such as a psychiatric hospital, a public health agency, or a children's hospital. Ward classes were visited and

an examination made of student records, minutes of committee meetings, et cetera.

From the visit and the written materials the visitors wrote a report which described the educational program, i.e., organization and administration, instructors, student personnel services, curriculum, evaluation, library, setting for the educational program, records, reports and announcements. The main purpose of writing the report is to give a clear, accurate picture of the program to the board of review, who will evaluate each program and provide, for each school, a summary of some factors indicating major strengths in its program, as well as the areas requiring study and improvement. There will be no published grading of schools at this time, but the status of the school will be determined and recommendations made for desirable goals.

To assist in the evaluation of this study, the schools involved have been asked to evaluate this entire process. The guide questions used are:

1. What have you liked in this evaluation procedure? (strengths)
2. What procedures might be improved? (weaknesses)
3. What suggestions for change in procedure would you recommend?
4. After having participated in this survey of the Pilot Project, do you believe the accreditation of schools of nursing in Canada would be desirable? Why?
5. Other comments.

The comments were most encouraging, and indicated that much assistance had been given in their participation in this project. Comments also indicate that if a Canadian accreditation program were initiated, more time should be spent in the evaluation of the nursing service areas where the students spend a large proportion of their time.

The Canadian Nurses' Association realizes that this project cannot be successful without the co-operation of other professional groups. To help interpret the project to these groups, the Canadian Nurses' Association has established a liaison committee which includes representatives from the Canadian Hospital Association, the Canadian Medical Association, the Canadian Public Health Association, and the Canadian Association for Adult Education.

What are the methods by which schools are now judged? What are the aims of national accreditation?

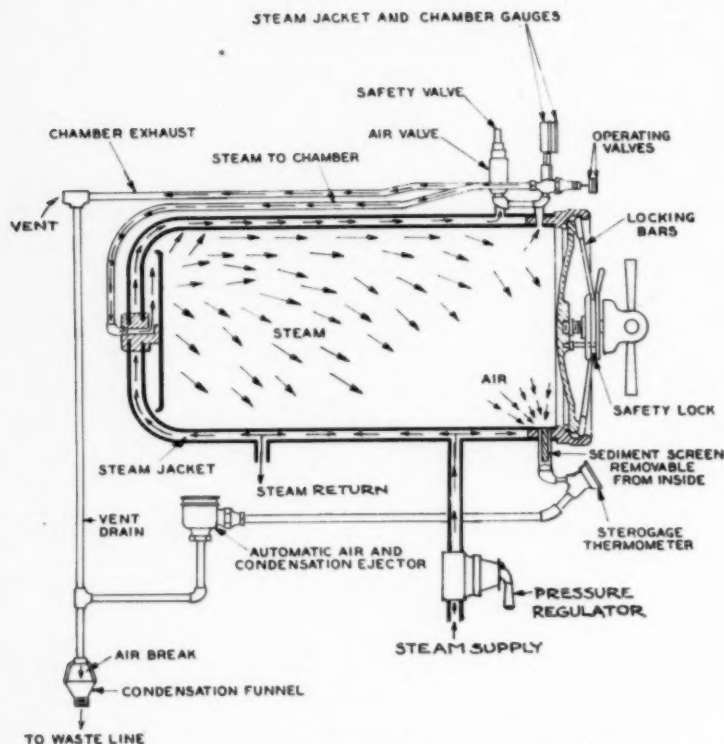
Under authority of the provincial acts, all schools of nursing in Canada are approved. The approving agency may be the provincial nurses' association, as in British Columbia, Manitoba, Quebec and the Atlantic Provinces; the provincial university, as in Alberta; and the provincial department of health, as in Ontario. Approval is compulsory and is based on minimum standards which are designated in the nursing act or in regulations authorized by the act. It indicates that the school has met minimum standards, its graduates are eligible to write examinations for registration, and, presumably, the public is safeguarded from incompetent practitioners.

The primary aim of an accreditation program is to improve nursing services by improving the preparation of nurses for that service. This is accomplished by the assistance given to schools through the accrediting process, in evaluating their own program and effecting improvements where weaknesses are found. Accreditation is voluntary and national in scope. Accreditation would be a seal of approval awarded to a school by the national organization after survey and evaluation. It would indicate the program had met the criteria formulated by the profession and was worthy of public recognition. These criteria would be subject to change as the nursing profession changes under the impact of medical and social sciences. Because no national criteria for evaluation are available in Canada, we are assessing the schools of nursing in this study on the basis of the National League for Nursing's criteria.

At this moment, the C.N.A. Committee on Nursing Education is working on a tentative statement of criteria which could be used if a national program of evaluation is initiated. It should also be noted that in surveying the educational program, the school is evaluated not only on the established criteria, but also within the framework of its own stated purposes and functions, and every effort is made to determine the effectiveness with which the educational program has been planned to fulfill them. Although the purposes of the school must be in harmony with those accepted by the profession, this system permits a broad range in which the school may initiate new ideas to the limits of its faculty's vision. The accrediting process is seen as an educational venture in which the

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Maintaining Hospital Sterilizers



Typical double shell or jacketed steam pressure sterilizer

Ira Markwood, P.E.,
Rochester, N.Y.

BECAUSE even a two degree sterilizing temperature variation can mean the difference between sterile and unsterile instruments and dressings, there is no room for compromise in hospital maintenance. The condition of these articles can determine the possibility of infection and possible death of a patient. With some equipment and processes it is possible to be careless and at the same time relatively successful. In hospital sterilization there

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can be no question of the degree of success—either material is sterile or it is not. If it is not, it is totally unacceptable.

There are many types of sterilizing equipment in our hospitals, but the most common is the double jacketed steam-pressure autoclave. When properly used and properly maintained, it will ensure sterility, but like any other piece of mechanical equipment, it must receive proper care by informed personnel. Among the most important of these persons is the hospital service or maintenance man, who should consider himself a part of

the operating team whether he ever sees an operating room in use or not.

The double shell or jacketed steam-pressure sterilizer basically consists of an outer steam jacket and an inner sterilizing chamber. (See sketch) The steam enters the jacket and then passes into the chamber through a steam-to-chamber valve. It is dispersed upward and outward by a baffle at the rear of the chamber. Steam, being lighter than air, causes stratification, forcing the air down, forward and out of the chamber through the sediment screen, into the air and condensation line. Pure, saturated steam at 15 pounds pressure produces a temperature of 250°F. A sterilizing cycle of 30 minutes at this temperature will kill any known organism. If there is air present in the chamber, it is possible to have pressure and not the proper temperature. Because of this possibility, the pressure gauges should be used in conjunction with the temperature gauge. Temperature is the all important factor.

If a direct steam sterilizer is being used, the steam will enter the outer jacket through first a strainer and then a pressure regulator. If the strainer becomes clogged, it will exert a throttling effect on the steam and consequently the sterilizer will not attain the proper pressure despite a perfectly functioning pressure regulator. The steam strainer should be checked and cleaned periodically. The time between inspections will vary with the condition of the steam and boiler. At the start it would be wise to check the strainer at least weekly. Subsequent inspection will establish a routine maintenance schedule.

If it is necessary to remove the pressure regulator from the line for servicing, it should be replaced with the steam flow indicating arrow on the valve pointing in the same direction as when it was removed.

The flow of steam through the pressure regulator is controlled by a piston moving within a cylinder and seating and unseating itself. Around the cylinder is a fine mesh screen that filters out any small particles of foreign material that may have passed the strainer. This assembly is called a renewal unit. The renewal unit can easily be removed as a whole by taking off the cover at the end of the valve. It may be

necessary to clean this unit from time to time if the cylinder is sticking. It goes without saying that if the cylinder sticks in the closed position, no steam will enter the sterilizer. If it sticks in the open position, steam pressure cannot be controlled and the safety valve will pop.

Long experience has indicated that one of the major causes of sticking pistons is boiler compound. A word to the wise on this subject should be sufficient.

The next component to be considered is the safety valve. It is a simple mechanism which normally needs very little servicing. The only danger inherent in the safety valve is that it may become inoperative from disuse. The handle on the valve should be lifted routinely once daily to ensure that it is in proper working order.

If the safety valve pops continuously, it should be an indication that in all probability the pressure regulator is not functioning properly. Adjusting the safety valve under these circumstances is a wholly unacceptable procedure. It is necessary to correct the cause of the trouble in the regulator, not the effect in the safety valve. In the case of older sterilizers there is the possibility that the spring in the safety valve has lost its tension. In this case the valve should be returned to the manufacturer for replacement of the spring and calibration. The pressure gauges will indicate which case is being dealt with.

Pressure gauges are used to indicate jacket and chamber pressures. It bears repeating that they should not be relied on as infallible indicators of proper sterilization—which is determined solely by temperature. They should be used only in conjunction with readings taken from the sterogage thermometer. The gauges themselves can and should be adjusted if they do not show a zero reading when pressure is absent. The cover glass can be removed and the indicating hand adjusted by holding the hand firmly and inserting a small screwdriver into the slot of the hand. Turn the screwdriver in a direction opposite to that in which the hand is being adjusted.

The sterogage thermometer cannot be repaired or adjusted if it ceases to operate satisfactorily. It must be replaced. The thermometer is located in the coldest part of the sterilizer and as long as it registers 250°F. you may be cer-



Figure 1

The pointer needle of the pressure gauge is easily adjusted. After removing cover glass insert a small screw driver in the screw in the centre of the pointer hand. Holding the pointer firmly turn the screw in a direction opposite the desired adjustment. More recent gauges, also shown, have a separate adjusting screw.



Figure 2

When it is necessary to replace the bellows in the thermostatic trap, for best performance it is wise to replace the seat at the same time. The gasket should be replaced each time the trap is opened.



Figure 3

Although parts can be obtained separately, it is best to replace the renewal unit of the steam regulator as an assembly. It is not necessary to disassemble the complete regulator—merely remove the back plate.



Figure 4

For top performance, periodic cleaning of the steam strainer basket is a must. This is easily done without removing the strainer from the sterilizer.

tain that the chamber temperature exceeds this reading and proper sterilization is being accomplished.

A sediment screen is located in the discharge line just ahead of the sterogage. Its purpose is to keep foreign matter such as needles and lint out of the line and thus prevent clogging of the air and condensation trap. The sediment screen should be inspected daily and cleaned as necessary. If it is not open, the sterilizer will be slow in operation and may not reach sterilizing temperature.

The air and condensation trap is operated by a bellows that functions upon contact with heat.

In the "rest" position the trap is open. When steam hits the bellows it expands and closes. As the steam condenses, the bellows opens again and allows the condensate to pass through the drain line. The bellows is thus in constant motion and might be referred to as the lungs of the sterilizer. If it sticks in the closed position, condensate will eventually back up into the sterilizer. If it sticks in the open position, steam will enter the drain line and it will be impossible to build up pressure in the chamber.

The jacket-return carries off condensation in the same manner as the chamber condensation trap. If it does not operate properly,



Figure 5

Daily tripping of the safety valve lever is good routine practice to ensure that the valve will be clean. Many plumbing codes insist that the lead seal not be broken. For this reason the valve should be returned to the sterilizer manufacturer when repair or adjustment is necessary.

water will back up into the jacket causing a loud hammering noise when the steam supply valve is opened.

A common complaint among operating personnel deals with wet dressings. There are several reasons for this, some the fault of the sterilizer, some not. The causes and prevention are as follows:

1. On manually controlled equipment, wet dressings may be due to faulty operation. At times an operator who is rushed will turn the vent or exhaust-from-chamber valve with one hand and the steam-to-chamber valve with the other—invariably the result will be wet dressings.

2. Wet dressings may be caused by the steam trap in the air and condensation line not working properly. Remove the bellows from the steam trap and see that the trap and all parts are perfectly clean. Check the bellows by placing it under an open steam line to see that it expands as it should. If it does not expand when placed under flowing steam, it should be discarded and a new one installed. When one reassembles the trap, the bellows assembly should be installed in the trap body first and the gasket placed on top of the plate to which the bellows is attached. Replace the cover of the trap and tighten the screws uniformly — just tight enough so the trap does not leak. When installing a new bellows in the trap, it is good practice to use a new seat and gasket with the new bellows.

3. Wet dressings may be caused by a clogged discharge line. Remove the sediment screen in the drain line at the front opening in the bottom of the sterilizer and see that it is not clogged. If dirty, it can be cleaned by scrubbing with a stiff brush until all dirt is removed and all holes in the screen are clean. Then check the drain line to see that it is clear through the condensation line.

4. Wet dressings may be caused by the sterilizer not being installed properly. If condensate lies in the bottom of the sterilizer chamber, the sterilizer should be tipped to the front slightly. This is done by screwing the front feet farther into the legs of the stand. The sterilizer should be set so all water or condensate drains to the front opening in the bottom. A good test is to pour a tumbler of water into the chamber. If it

(concluded on page 97)

Physiotherapy in Canada

by
Helen M. Gault,
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A PILOT study of departments of physiotherapy in Canada in all known hospitals and centres with accredited departments was published in 1958.* The purpose of this study was to discover the distribution of therapists province by province in relation to their population; also the ratio of the total number of beds, in hospitals with physiotherapy departments, to total population. Material was gathered on numbers of patients and treatments, size of departments and amount of apparatus, the nature of in-service education for therapists and participation by therapists in the education of nurses, physiotherapy students and, where applicable, medical students.

The section dealing with patients and treatments required elaboration if the figures were to be useful as a reliable guide to those requesting information concerning the establishment of new departments. It was therefore decided that a second study was necessary and the research undertaken in this report has the following objectives:

1. To elicit the proportions of in-patients to out-patients.
2. To determine the value of a time-unit system and the units of time most acceptable to therapists for each technique.
3. To ascertain the medical and surgical conditions demanding the most time for treatment.
4. To ascertain the number of treatments, numbers and kinds of

treatment techniques and time values for these techniques.

5. To determine ratios of treatment time-units to therapist hours.

6. To elicit and analyze charges for treatments.

Sample

Distribution of the questionnaires was based upon an analysis of the list of general hospitals in the 1958 pilot study. From this were chosen general hospitals having one full-time therapist or more. This group was selected because details of departments and apparatus are already on file as a source of further information. Hospitals were divided into three bed-groups, 1—199, 200—499 and 500 and over. This division resulted from the analysis of the pilot study which showed that the 200—499 group appeared to have a poorer therapist bed ratio and less apparatus than the other two groups. General hospitals in all provinces were included. There were 103 questionnaires distributed and 72 complete returns were received. This report, therefore, is based upon 69.9 per cent of the group surveyed.

Method

A comprehensive questionnaire was drafted and distributed to obtain the following information: (a) whether or not a time-unit system is used; (b) the therapist's opinion of the most suitable number of time-units for each technique; (c) the in-patient to out-patient load for a four-week period; (d) the number of treatments and techniques in the four-week period; (e) the charges for treatments.

November 1958 was chosen as the test month because it had no statutory holiday, a minimum of

conditions
techniques
time-units
in the general hospital

staff on vacation and a minimum of graduate interns to affect the ratio of therapists to patients. Sheets were provided for each week in the month to minimize the charge therapist's task of reporting and to obtain daily entries of totals of treatments under the appropriate headings of in-patients and out-patients for 13 principal conditions treated. The following legend was supplied as a guide to sub-divisions of conditions to be included under each heading:

Orthopaedic—Surgical and non-surgical bone abnormalities, surgical osteoarthritis and rheumatoid arthritis, fractures, postural deformities, amputations

Osteoarthritis—Non-operative cases

Rheumatoid Arthritis—Articular rheumatoid conditions, spondylitis, collagen diseases

Obstetrics—Pre- and Post-natal cases

Pre and Post-operative—All general surgical cases excluding chest and heart operations

Medical Chest Conditions—All non-operative chest and heart cases

Surgical Chest Conditions—All chest and heart surgery, pre- and post-operative

Circulatory Diseases—Arteriosclerosis, thrombosis in extremities, Buerger's disease, Raynaud's disease, skin temperature tests, et cetera.

Soft Tissue Injuries—Sprains, strains, contusions, oedema, burns, skin grafts, bed sores, ulcers, plastic surgery, tendon repair, muscle spasm, et cetera.

Neurology—Brain and spinal cord diseases, non-surgical nerve lesions, peripheral neuritis, herpes zoster, et cetera.

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*A report on *Physiotherapists in Canada. Canadian Hospital*, Aug. and Sept. 1958.

Table 1
Percent of Agreement with Suggested Time
Units for Techniques

| Techniques | Suggested Unit Value (15 Mins. Per Unit) | Correct % | Opinion of Therapist | |
|-----------------------------|---|--------------|----------------------|----------------|
| | | | Too Long % | Too Short % |
| <u>Partial Supervision</u> | | | | |
| Short-Wave | 2 | 92 | 4 | 4 |
| Infra-Red | 2 | 87 | 8 | 5 |
| Whirlpool | 2 | 89 | 6 | 5 |
| Wax Bath | *1 | 46 | 0 | 54 |
| Hot Packs & Steam Baths | 3 | 88 | 12 | 0 |
| Ultra Violet | 1 | 97 | 3 | 0 |
| Traction | 1 | 65 | 0 | 35 |
| Apparatus Exercise | 1 | 62 | 0 | 38 |
| Venous Occlusion | 4 | 85 | 13 | 2 |
| Constant Current | 2 | 94 | 5 | 1 |
| <u>Constant Supervision</u> | | | | |
| Hubbard Tank | 3 | 89 | 2 | 9 |
| Ultra Sonar | 1 | 93 | 2 | 5 |
| Muscle Stimulation | 1 | 60 | 1 | 39 |
| Manual Muscle Testing | 3 | 85 | 3 | 12 |
| Electrical Muscle Testing | 1-2 | 75 | 1 | 24 |
| Individual Exercises | 1 | 70 | 0 | 30 |
| Class Exercises | *1 | 47 | 0 | 53 |
| Massage & Manipulations | 1 | 90 | 7 | 3 |

*Adjusted to 2 Units

Neurosurgery—Brain and spinal cord post-operative cases, peripheral nerve sutures.

Skin Conditions—Psoriasis, acne, et cetera.

"Other" Conditions—Any conditions which will not fit into the above categories.

Both adults and children should be included.

A breakdown of treatments, in-to techniques was required during the last week of the test month. For this breakdown single sheets were provided for each condition to facilitate daily entry of work accomplished and avoidance of an

undue accumulation of work at the end of the period.

To assess the value of the time-unit system a value of 15 minutes was chosen for each unit. A list of 18 physiotherapy techniques, with a suggested number of time-units per technique, was provided and therapists were asked to indicate whether the time-unit allotment per technique was too long, too short or correct.*

Findings

Proportion of in-patients to out-patients

During the test week the reported proportion of total in-

patients to total out-patients was similar to that for the entire month of November. In all groups there were more in-patients than out-patients. In the two hospital groups listed as having 200-499 beds, and 500 and over, the number of in-patients was 70 per cent and 60 per cent respectively to that of out-patients. In the smallest bed-group there were about 50 per cent more in-patients.

*The author wishes to acknowledge the kind assistance of the Institutions Section of the Dominion Bureau of Statistics in preparation of the tables.

Table 2
Rank Order and Percentage of Treatments for 6 Main Conditions
in 3 Groups of General Hospitals During Test Week

| Condition | 1 - 199 Beds | | | 200 - 499 Beds | | | 500+ Beds | | |
|------------------------|--------------|------|------------|----------------|------|------------|-----------|------|------------|
| | Number | Rank | Percentage | Number | Rank | Percentage | Number | Rank | Percentage |
| Orthopaedic | 968 | 1 | 33.7 | 2393 | 1 | 44.1 | 2747 | 1 | 27.6 |
| Soft Tissue Inj. | 576 | 2 | 20.0 | 581 | 3 | 10.7 | 1181 | 3 | 11.6 |
| Obstetrics | 320 | 3 | 11.1 | 349 | 4 | 6.4 | 549 | 6 | 5.5 |
| Neurology | 228 | 4 | 7.9 | 624 | 2 | 11.5 | 1586 | 2 | 16.0 |
| Sub Total | | | 72.7 | | | 72.7 | | | 60.5 |
| Pre and Post Operative | 186 | 5 | 6.5 | 315 | 5 | 5.8 | 734 | 4 | 7.4 |
| Osteoarthritis | 221 | 6 | 7.7 | 253 | 6 | 4.7 | 575 | 5 | 5.8 |
| Sub Total | | | 86.9 | | | 83.9 | | | 73.7 |
| Other | 387 | | 13.1 | 913 | | 16.1 | 2469 | | 26.3 |
| Total | 2886 | | 100.00 | 5428 | | 100.00 | 9841 | | 100.00 |

Table 3

Rank Order and Percentages of Time-Units Consumed by 5 Principal Conditions Treated in Physiotherapy Departments in General Hospitals in Test Week.

| Condition | 1 - 199 Beds | | | 200 - 499 Beds | | | 500+ Beds | | |
|------------------|--------------|----------------------|--------------------------------|----------------|----------------------|--------------------------------|-----------|----------------------|--------------------------------|
| | Rank | Number of Time Units | Percentage of Total Time Units | Rank | Number of Time Units | Percentage of Total Time Units | Rank | Number of Time Units | Percentage of Total Time Units |
| Orthopaedic | 1 | 2733 | 34.4 | 1 | 4980 | 44.2 | 1 | 7069 | 29.7 |
| Soft Tissue Inj. | 2 | 2181 | 27.4 | 2 | 1519 | 13.5 | 3 | 3517 | 14.8 |
| Osteoarthritis | 3 | 702 | 8.8 | 5 | 720 | 6.4 | 4 | 2388 | 10.0 |
| Neurology | 4 | 564 | 7.1 | 3 | 1260 | 11.2 | 2 | 3993 | 16.8 |
| Rheumatoid | 5 | 532 | 6.7 | 4 | 750 | 6.7 | 5 | 2131 | 9.0 |
| Sub Total | | | 84.4 | | | 82.0 | | | 80.3 |
| Other | | 1296 | 15.6 | | 2037 | 18.0 | | 4675 | 19.7 |
| Total | | 8008 | 100.0 | | 11266 | 100.0 | | 23773 | 100.0 |

Value of the Time-Unit System and Number of Time-Units Most Acceptable to Therapists

The techniques were divided into two groups. The first group, headed "Partial Supervision", showed techniques demanding only part (about one third) of the therapist's time to set up the treatment and explain the procedure to the patients. The second group headed "Constant Supervision" showed techniques demanding the whole attention of the therapist.

Table 1 presents the division of techniques into two groups and the analysis of replies into percentages. It is apparent that the suggested unit value for wax baths and class exercises should be increased to two time-units. Several replies stressed that techniques involving lumbar traction, slings and weight apparatus may demand more than the allotted time to allow for adjustment of apparatus.

Fifteen hospitals in this survey already employ a time-unit system of recording, varying from 15 to 30 minutes per unit, and all these are in favour of its continuation. Forty-six other hospitals considered the system would be advantageous in assessing the departmental work and 47 therapists thought that it would simplify the patient charge sheets.

Medical and surgical conditions demanding most treatment time

Table 2 shows the rank order of six groups of medical and surgical conditions treated during the test week. The actual number of treatments done in each group is given as well as their percentages of total

treatments for that week. Of the untabled conditions, rheumatoid conditions ranked 7th in all bed-groups; medical chests ranked 8th in the two smaller groups; but in the largest bed-group neurological conditions was 8th with 4.6 per cent of total treatments; and medical and surgical chests 9th and 10th with 3.8 and 3.2 per cent, respectively; surgical chest cases were only .2 per cent in bed-group 1 and 2, and the number of treatments of circulatory conditions and skin diseases were very small in all groups. In the category of "Other Conditions", 75 per cent of those reported could have been listed under a more specific heading. The remaining 25 per cent was composed of sinusitis, pelvic inflammatory disorders, psychoses, neuroses and certain medical con-

ditions, such as diabetes. Nine hospitals did not specify a diagnosis.

Numbers of Treatments, Techniques and Time-Units Involved

Conditions listed under the headings of *Orthopaedics* were seen to have consumed the largest number of time-units in each bed-group. Five of the 13 listed conditions accounted for over 80 per cent of the time-units in each stratum. This 80 per cent of time-units represented 73 per cent, 75 per cent, and 67 per cent of the total treatments in the small, medium, and large hospitals respectively. Of all the treatments given, 55, 62 and 51 per cent of these five conditions were in-patients in the respective hospital groups.

Table 3 shows treatment time-units in each of the five principal

Table 4

Time Units for 5 Principal Conditions According to Constant or Partial Supervision of Therapist During Test Week

| Condition | Treatment Time-Units | | | | | |
|------------------|-----------------------------------|-----------|-----------|----------------------------------|-----------|-----------|
| | Constant Supervision By Therapist | | | Partial Supervision by Therapist | | |
| | 1 - 199 | 200 - 499 | 500+ Beds | 1 - 199 | 200 - 499 | 500+ Beds |
| Orthopaedic | 1215 | 2514 | 3213 | 1518 | 2466 | 3856 |
| Soft Tissue Inj. | 793 | 495 | 1212 | 1388 | 1024 | 2305 |
| Osteoarthritis | 244 | 174 | 675 | 458 | 546 | 1713 |
| Neurology | 323 | 791 | 2673 | 241 | 469 | 1320 |
| Rheumatoid | 197 | 257 | 876 | 335 | 493 | 1255 |
| | 2772 | 4231 | 8649 | 3940 | 4998 | 10449 |

conditions treated in physiotherapy departments and percentages of these time-units to the total treatments for all conditions.

Table 4 is a subdivision of the time-unit returns in Table 3. The two groups are titled, respectively, *Constant Supervision* and *Partial Supervision*. In all three hospital groups the number of time-units absorbed by treatments under constant supervision were fewer than those under partial supervision. In total, constant supervision treatment time-units for the five principal conditions were 29.7 per cent lower than partial supervision in the first bed-group, 15.5 per cent lower in the second bed-group and 17.24 per cent lower in the third bed-group. The treatment techniques most frequently used have been analyzed.

Table 5 shows the rank order, number and percentage of time-units for the five most time-con-

suming techniques requiring constant supervision by the therapist for the five main conditions of Table 4. In all bed-groups individual exercises and massage, together, account for over 80 per cent of the total time-units. If the next three in importance are added, the totals are over 93 per cent in all strata.

Table 6 shows the rank order, number and percentages of time-units of the five most time-consuming techniques requiring partial supervision by the therapist for the main five conditions listed in Table 4. These techniques account for over 90 per cent of the techniques for the two smaller hospital groups. In the largest hospital group, hot-packs and steam baths account for 9.9 per cent of all techniques and rank fourth. In the smallest hospital group cervical traction ranked fifth with 4.4 per cent.

Ratio of treatment time-units and therapist hours

Analysis of all reports on total treatments, techniques, and time-units revealed 1.89 techniques and 2.42 time-units per treatment, with techniques under partial supervision bearing a ratio of 1:1.05 to those under constant supervision. On an average, there were almost twice as many techniques as treatments and at least half of the techniques required constant supervision.

By size of hospital, the ratio of partial to constant supervision techniques was 1:1.31 in the 1-199 bed-group; and 1:1.06 for 500 beds and over. In contradistinction, the ratio of constant to partial supervision was 1:1.02 on the 200-499 bed-group.

Excluding the lunch hour, the working hours per week were assumed to be seven hours per week.

Table 5
Constant Supervision

| Treatment | 1 - 199 Beds | | | 200 - 499 Beds | | | 500+ Beds | | |
|--------------------|-------------------|------|--------------------------------|-------------------|------|--------------------------------|-------------------|------|--------------------------------|
| | No. of Time Units | Rank | Percentage of Total Time Units | No. of Time Units | Rank | Percentage of Total Time Units | No. of Time Units | Rank | Percentage of Total Time Units |
| Individual Ex. | 1556 | 1 | 56.1 | 2695 | 1 | 63.7 | 5894 | 1 | 68.2 |
| Massage | 716 | 2 | 25.8 | 792 | 2 | 18.7 | 1160 | 2 | 13.4 |
| Sub Total | | | 81.9 | | | 82.4 | | | 81.6 |
| Muscle Stimulation | 133 | 3 | 4.8 | 175 | 4 | 4.1 | 185 | 5 | 2.1 |
| Hubbard Tank | 132 | 4 | 4.8 | 108 | 6 | 2.6 | 675 | 3 | 3.3 |
| Ultra Sonar | 115 | 5 | 4.4 | 238 | 3 | 5.6 | 288 | 4 | 7.8 |
| | | | 95.9 | | | 94.7 | | | 94.8 |
| Other | 120 | | 4.1 | 223 | | 5.3 | 446 | | 5.2 |
| Total | 2772 | | 100.0 | 4231 | | 100.0 | 8648 | | 100.0 |

Table 6
Partial Supervision

| Treatment Techniques | 1 - 199 Beds | | | 200 - 499 Beds | | | 500+ Beds | | |
|----------------------|-------------------|------|--------------------------------|-------------------|------|--------------------------------|-------------------|------|--------------------------------|
| | No. of Time Units | Rank | Percentage of Total Time Units | No. of Time Units | Rank | Percentage of Total Time Units | No. of Time Units | Rank | Percentage of Total Time Units |
| Short Wave | 2170 | 1 | 55.1 | 2598 | 1 | 52.0 | 4136 | 1 | 39.6 |
| I.R.R. | 738 | 2 | 18.7 | 998 | 2 | 20.0 | 1698 | 2 | 16.2 |
| Whirlpool | 304 | 3 | 7.7 | 286 | 5 | 5.7 | 1134 | 3 | 10.9 |
| Wax Baths | 276 | 4 | 7.0 | 393 | 4 | 7.9 | 934 | 5 | 8.9 |
| Apparatus Ex. | 161 | 6 | 4.1 | 412 | 3 | 8.2 | 922 | 6 | 8.8 |
| | | | 92.6 | | | 93.8 | | | 84.4 |
| Other | 291 | | 7.4 | 311 | | 6.2 | 1625 | | 15.6 |
| Total | 3940 | | 100.0 | 4998 | | 100.0 | 10449 | | 100.0 |

day and four hours on Saturday. At 15 minutes per time-unit, this allows 164 time-units per week for treatments requiring constant supervision. However, each such constant supervision unit is offset by one unit of partial supervision, requiring 5 minutes per 15 minute period. During one hour, therefore, a therapist could give 3 techniques under constant supervision and 3 techniques under partial supervision. Theoretically, 228 time-units per week are thus available for treatment. This total is, of course, impossible. It permits no time for administration, house-keeping, study of case histories, doctor's conferences, rounds or clinics, passage between wards or interdepartmental communications.

The reported range of time-units per therapist per week was from 59-372. The mean for all scores was 154.3. The standard deviation 54.8 indicated so wide a range that the mean was of little value. To find alternative values, the mean number of time-units per therapist per week was first calculated for each of the small, medium and large hospitals. The mean was 167, 148 and 168 respectively. The hospitals were then assembled into groups of 100 beds per group.

Table 7 shows the average time-unit per therapist per week for each of these 100 bed groups. In each of the four of these groups this average falls between 156 and 166 and thus approximates the mean of 154.5 for all scores.

If the average count of 154.4 time-units per therapist could be accepted as valid then every therapist having a case-load corresponding to this figure would spend 2 hours 12 minutes per 7 hour day for administration and other non-treatment purposes. This will be discussed in the conclusion. Calculations based upon hospitals with therapists, plus remedial gymnasts and unqualified workers, differed so slightly from those hospitals with therapists only that, for the sake of brevity, they were not listed under separate headings for the purpose of this report.

Conclusion and Summary

Returns from 72 hospitals which reported on physiotherapy treatments and techniques were divided into three groups having, respectively, 1-199, 200-499, and 500 and over beds. Of the 72, 61 were in favour of the time-unit system and Table 1 shows an analysis of units in terms of 15 minutes per unit. All techniques were divided into two categories, those requiring

Table 7
Average Time-Unit Per Therapist Per Week by Size of Hospital

| Number of Beds | Number of Hospitals Reporting | Average Number of Therapists per Hospital | Average Time-unit per Therapist per Week | Range | |
|----------------|-------------------------------|---|--|-----------------------|-----------------------|
| | | | | Minimum per Therapist | Maximum per Therapist |
| 1 - 99 | 3 | 1.25 | 195 | 105 | 270 |
| 100 - 199 | 21 | 1.6 | 166 | 59 | 372 |
| 200 - 299 | 12 | 1.5 | 158 | 81 | 219 |
| 300 - 399 | 4 | 4.2 | 136 | 98 | 213 |
| 400 - 499 | 10 | 2.6 | 135 | 59 | 205 |
| 500 - 599 | 4 | 5.0 | 121 | 65 | 188 |
| 600 - 699 | 4 | 4.2 | 165 | 93 | 200 |
| 700 - 799 | 5 | 7.4 | 177 | 154 | 213 |
| 800 and over | 7 | 8.6 | 156 | 104 | 206 |

constant supervision by the therapist and those requiring only partial supervision. Details of principal conditions treated, techniques, and time-units involved are reported in Tables 2 and 3. Orthopaedic conditions appear to form the highest percentage of time-units. In the smallest hospital group, it is interesting to note that obstetrics rank third in number of treatments but only seventh in time-units consumption. In the 500 and over bed group, neurological conditions rank second, both in number of treatments and time-units. In Tables 4, 5 and 6, under each bed-group and also under the further categories of "constant" and "partial" supervision by the therapist, the total time-units of the five principal conditions are given. These figures are also broken down to indicate the most frequently used techniques. The medium-sized hospitals appear to show a low total time-unit count in comparison with the other two groups; and there is a possible explanation of this low total. The medium hospitals seem to favour techniques with a low time-unit count, such as ultrasonar or exercises with apparatus, whereas the larger and smaller hospitals seem to make more use of some, or all, of the techniques with a higher time-unit count, such as whirlpool, wax baths, and hubbard tanks.

The analysis of therapist-hours and time-units showed that units per therapist ranged from 59 to 372. The maximum available time-units per therapist per 5½ day week, based upon a seven-hour full day, are calculated to be 228. The total is derived from a case load of 6 units per hour, half of the treat-

ments under constant supervision and half under partial supervision. It must be remembered that the time-units in Table 1 are in terms of apparatus and/or therapist-time. In the constant supervision division, the time-unit total for each technique refers entirely to therapist-time. In the partial supervision division, only five minutes per unit of 15 minutes refers to therapist-time. This calculation makes no allowance for administrative and other non-treatment duties which, if the calculated mean of time units per therapist per week is reliable, would appear to occupy an average of two hours and 12 minutes of each day. Even without this allowance it is apparent that some physiotherapy departments are asked to provide treatment techniques far in excess of the number which would appear to be effective, according to the time-unit analysis of Table 1, however ideal the conditions.

The mean of 154.5 time-units per week per therapist cannot be accepted as statistically reliable because of the high standard deviation. Yet argument can be presented in its favour by comparing this mean with the respective means (167, 148 and 168) of the three main bed-size groups of hospitals. This could be amplified by showing that the 1-199 bed-group has only an equal number of in-patients and out-patients, thus reducing the time walking to and from the wards. Also, the distance from department to wards is shorter than in larger hospitals. Also, as a rule, clinics and ward-rounds are fewer or non-existent and there is a minimum of book-keeping. In contrast,

hospitals in the 200—499 bed-group are relatively poorly supplied with therapists for, out of 27 returns, 12 report having only one therapist. The treatment of 50 per cent more in-patients than out-patients in this group necessitates walking to and from the wards, over greater distances than in the small hospitals. Many require therapists to attend clinics and rounds, and secretarial assistance is poor (Survey 1958). It is therefore understandable that their time-unit per therapist is lower than in smaller hospitals.

In the 500 and over bed-group the mean is 168. Although there are more clinics and rounds, and a greater floor space, the higher proportion of therapists per 100 beds permits the allocation of therapists to fixed areas and minimal walking within those areas. In addition, they are supported by a higher percentage of orderlies and secretarial staff. These factors may have the effect of reducing the large hospitals to several small units which are governed by the charge therapist, as a co-ordinator, but each of which is otherwise comparable to the smallest bed-size group.

If the hypothesis is accepted

that the mean of 154.4 time-units per therapist per day, shows grounds for reliability, then the possible spread of time-units per therapist per week could be set at 134-174, leaving two hours and 50 minutes to 1 hour 38 minutes, per day per therapist, as the maximum to minimum time not spent in actual treatment. It will be remembered that the mean time of 154.5 allowed 2 hours and 12 minutes non-treatment time per day. As each therapist must have time for doctors' or other hospital rounds, clinics, administration, housekeeping, liaison with other departments, walking to and from wards and the inevitable waiting for patients, it is the opinion of the writer that the estimated time away from patient treatment is not too long.

The table analyzing the charges made to patients shows a wide variety in each hospital group. The minimal-maximal spread is smaller in the 500 and over bed-group because of this group's lower charges for ultrasonar, electrical testing, massage and post-natal series of exercises.

Recommendations

It is well understood that many hospitals with time-unit counts

far above average may not feel there is an insufficient time for treatment because of the nature of the techniques and the concentration of patients in one hospital area. For example, one hospital reported having a very high proportion of pre- and post-operative cases. All these were treated individually in the wards and probably did not require the whole 15 minute period. However, such individual findings were rare. For the majority of hospitals, in view of the findings of the maximum and mean time-units in departments of physiotherapy, per therapist, per week, it is hoped that charge therapists with very high time-unit counts will reassess their treatment load in terms of the scale in Table 1. If the findings are consistently far above average, it is hoped that they will discuss these findings with the departmental directors, or with hospital administrators, in order that physiotherapists may have an opportunity of practising their profession under favourable conditions. Then patients may receive the quality of treatment to which they are entitled and for which they are presumably charged. ■

Table 8
Average Rates of Charges For Physiotherapy in General Hospitals

| Treatment | 1—199 | | | | 200—499 | | | | 500+ | | | |
|-----------------------------|------------------|-------|-------|------------|------------------|-------|------|------------|------------------|-------|------|------------|
| | No. of Hospitals | Max. | Min. | Avg. Chgs. | No. of Hospitals | Max. | Min. | Avg. Chgs. | No. of Hospitals | Max. | Min. | Avg. Chgs. |
| Partial Supervision | | | | | | | | | | | | |
| Short wave | 21 | 3.50 | 1.50 | 2.37 | 18 | 3.25 | 1.50 | 2.44 | 11 | 2.50 | 1.50 | 2.14 |
| Infra-red | 20 | 3.50 | 1.00 | 2.04 | 16 | 2.50 | 1.00 | 1.86 | 11 | 2.00 | 1.00 | 1.82 |
| Wax | 16 | 3.00 | 1.00 | 2.14 | 14 | 2.25 | 1.00 | 1.77 | 9 | 2.00 | 1.00 | 1.78 |
| Whirlpool | 12 | 3.00 | 1.00 | 2.31 | 11 | 3.00 | 1.75 | 2.16 | 9 | 3.00 | 1.00 | 2.06 |
| S F Bath | 2 | 2.25 | 1.50 | 1.87 | 2 | 2.25 | 2.25 | 2.25 | 2 | 2.00 | 1.50 | 1.75 |
| Traction | 15 | 3.00 | 1.00 | 1.63 | 10 | 2.00 | 1.00 | 1.61 | 5 | 1.50 | 1.50 | 1.50 |
| Constant Supervision | | | | | | | | | | | | |
| Ultrasonar | 8 | 3.00 | 1.50 | 2.35 | 7 | 5.50 | 2.00 | 2.93 | 8 | 3.00 | 2.00 | 2.56 |
| U.V.L. | 18 | 3.00 | 1.00 | 2.00 | 19 | 3.00 | .40 | 1.80 | 11 | 3.00 | 1.50 | 2.00 |
| Mass-gen. | 3 | 6.00 | 4.50 | 5.17 | 10 | 4.50 | 2.00 | 3.20 | 4 | 4.00 | 3.00 | 3.50 |
| Mass-local | 16 | 3.00 | 1.00 | 2.05 | 17 | 3.00 | 1.00 | 1.96 | 11 | 2.00 | 1.00 | 1.82 |
| Elec. stim. | 19 | 3.00 | 1.50 | 2.28 | 16 | 2.50 | 1.50 | 2.00 | 11 | 2.50 | 1.50 | 2.02 |
| Elec. test | 4 | 10.00 | 1.50 | 5.50 | 10 | 10.00 | 2.50 | 6.00 | 8 | 7.50 | 2.50 | 4.45 |
| Breath cl. | 5 | 3.00 | 1.00 | 1.90 | 7 | 2.00 | 1.00 | 1.43 | 3 | 2.00 | 1.00 | 1.58 |
| Individ. Ex. | 20 | 3.50 | 1.00 | 1.84 | 19 | 3.00 | 1.00 | 1.76 | 10 | 2.00 | 1.00 | 2.20 |
| Hubbard tk. | 3 | 3.00 | 1.50 | 2.33 | 3 | 5.00 | 3.00 | 3.67 | 6 | 4.00 | 2.00 | 3.00 |
| Mass. & Ex. | 3 | 4.00 | 3.00 | 3.33 | 7 | 3.00 | 2.50 | 2.75 | 5 | 3.00 | 1.50 | 2.50 |
| Combined Treatments | | | | | | | | | | | | |
| Heat & Mass. | 14 | 5.00 | 2.00 | 3.07 | 12 | 4.00 | 2.50 | 2.96 | 7 | 3.00 | 1.50 | 2.71 |
| Heat & Ex. | 11 | 5.00 | 2.00 | 3.18 | 10 | 4.00 | 2.00 | 2.85 | 5 | 3.50 | 2.50 | 2.90 |
| SW, Mass, Ex. | 15 | 5.00 | 2.50 | 3.88 | 9 | 4.50 | 2.50 | 3.33 | 7 | 3.50 | 2.00 | 2.86 |
| IR, Mass, Ex. | 12 | 5.00 | 2.50 | 3.75 | 9 | 3.50 | 2.50 | 3.11 | 6 | 3.50 | 2.50 | 2.92 |
| Pre-natal S | 3 | 15.00 | 10.00 | 12.33 | 6 | 15.00 | 1.25 | 9.04 | 2 | 12.00 | 6.00 | 9.00 |
| Post-natal S | 4 | 6.00 | 1.00 | 3.38 | 4 | 6.00 | 1.00 | 3.38 | 5 | 5.00 | 1.00 | 3.20 |

SUMMER SESSION STUDENTS

H.O.M. Graduating Class—Second Year Students



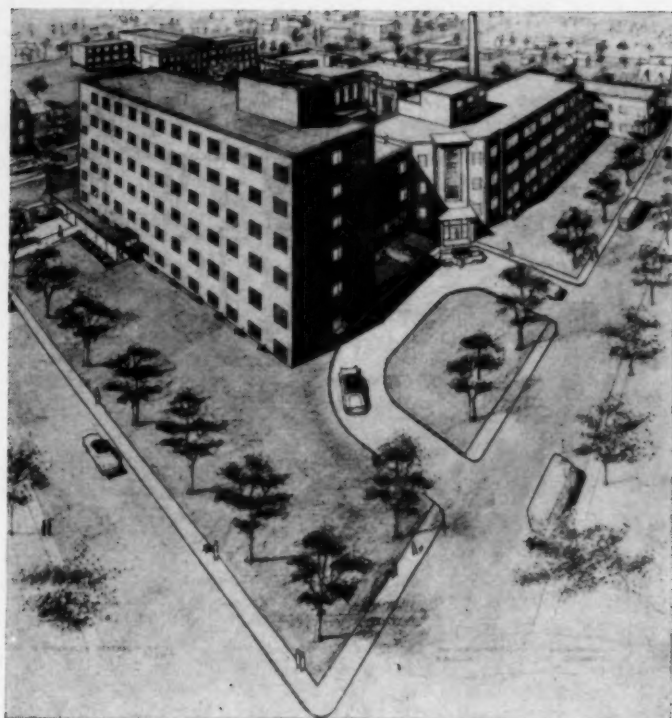
1st row: (l. to r.) Mary Mercer (staff), Sr. Rita, Sr. M. St. Anthony, Sr. Margaret Marie, Sr. Mary Francis, Sr. M. Lourdes, Sr. Saulnier, Sr. Ann Ell, Sr. Mary Clare, Sr. Patricia Ann, Betty Riddell, Sr. John of the Passion, Sr. Marie Alma Caruhal, Sr. Maria James, Sr. Mary M. Mackenzie, Sr. Cecilia Clermont, Sr. Dorothy Therese, Sr. Helen Levasseur, Sr. Marie Albert, Sr. Noella Ferguson. 2nd row: Ghislaine Majeau (staff), F. Whittaker, J. T. Mulligan, W. L. Hilton, M. P. Hourigan, W. E. Powell, L. E. Verret, R. Lachapelle*, J. G. Lacoste, M. G. Stanton, J. J. Minguy, Dr. M. C. Novack, Sylva M. Gelber*, Col. K. J. Coates, M.D., E. M. Browning, J. O. Dale, N. Kilburg, J. F. Cooper, E. Friesen. 3rd row: Mrs. D. Easter, B. W. Johnson, P. E. Russell, Dr. W. E. Noonan*, S. Worthington, J. Lysak, G. A. Grose, G. Burgess, A. W. Holtby, A. J. Forkheim, H. M. Anderson, E. H. Mills, H. A. Connolly, J. F. Retty, Dr. R. B. Goyette, R. S. Rigg, S. R. Lamattina, L. L. Wilson (staff). 4th row: Reta M. Brown, C. A. Cousins, J. H. MacCallum, K. B. Rutherford, W. W. Devine, K. G. Muir, R. D. Beaman, Lt. A. W. Hood, Lt. T. A. S. Kadey, C. C. Christianson, J. L. Pedden, Dr. M. A. Deacon, H. T. Hart, and R. H. Procter. Missing is Lt. R. C. Jones.

*These students have one more summer session to complete.

H.O.M. First Year Students



1st row: Mary Mercer (staff), Mrs. D. K. Edgeworth, Sr. M. T. Boulet, Elizabeth L. Clement, Edna I. Sheppard, Dorothy E. Doan, Mrs. M. O'Brien, Sr. M. Alexina, Sr. M. F. Cazabon, Sr. L. Godin, Sr. M. L. Murphy, Sr. Rose Marie, Sr. St. Jean de la Croix, Sr. M. Patrice, Sr. Rose-Therese, Sr. M. Marguerite, Sr. A. Leblanc, Sr. M. Stanislaus, Charlotte Cook, Sr. L. Gertrude, Sr. M. Hildegard, Gilberte Lanthier, Sr. M. Angelica, Sr. M. A. Celesta, Mrs. G. Edwards, D. J. Lefebvre, L. L. Wilson (staff). 2nd row: R. J. Baker, Corinne Eriksson, Ghislaine Majeau (staff), Sr. Adrienne, F/L N. E. Tompkins, V. F. Simpson, A. W. Read, J. W. Smith, B. Holden, J. W. Free, J. J. Benham, J. J. O'Keefe, F. G. Baker, Capt. R. F. R. Levesey, H. L. Livergant, S. M. Chapman, R. H. Gill. 3rd row: R. N. Christy, J. C. Allan, D. Ledoux, Dr. M. Berthiaume, M. D. Tice, A. S. Brown, W. O. Booth, W. E. Cooke, G. E. Mowat, P. Pauls, H. Wiskemann, W. N. Saranchuk, Dr. J. N. R. Scatliff, J. M. Logan, H. H. Sim. 4th row: P. E. Goschy, Capt. D. D. Perkins, Dr. A. Janauskas, G. Morgan, G. A. Cox, S. Duffy, H. E. Heckler, D. A. Biggs, Dr. C. J. Doherty, G. M. Barrow, G. S. MacKenzie, J. D. Snedden, F. C. Westwick, Dr. C. S. Gamble, L. D. Swenerton, J. R. Robson, N. D. Guy, and R. J. LePocher. Missing are Sr. C. Charles and G. C. Smith.



Brockville Plans Ahead

Architects: Drever and Smith, Kingston, Ont.

"A SMALL model of a modern metropolitan hospital" — that's what the Brockville General Hospital will be when its current expansion program has been carried out. So says the hospital's superintendent, James G. Wilson. He is proud of the future Brockville General, and he has every reason to be.

For five years now, expansion talk has been going on in Brockville, Ontario. Two years ago the matter was considered settled. There would be a four-storey west wing and a three-storey east wing. The nurses' residence would be doubled in size. But when federal and provincial government grants were increased, the expansion plans kept pace. Now the final design calls for a west wing of six storeys and a new east wing with two storeys above the basement. The nurses' residence will have 71 additional beds, plus facilities for teaching and recreation. Both power house and laundry will be enlarged.

This will be the second expansion for the hospital since World War II—the first cost \$600,000. The present program will cost over \$2,000,000. It will also add a substantial number of new beds to the hospital (179), bringing the total to just under 300.

In the new six-storey wing, there will be an outpatient department, an emergency department, x-ray treatment department, laboratory and physiotherapy departments. It will also have four modern operating rooms with recovery rooms.

The old building is not to be forgotten. Thirty-nine beds will be removed entirely, as will the old sun-parlours. This last step will permit the use of adjacent rooms. In addition to this, the building will be fire-proofed.

This ambitious program will take about two years. But everyone concerned feels that the new Brockville General Hospital will be worth the wait. ■

HORIZONS Unlimited, the theme of the Canadian Dietetic Association's 24th annual convention, proved to offer stimulation and a challenge to the 200 delegates and guests gathered in Winnipeg. A trip to the home economics department of the University of Manitoba, followed by a delightful buffet supper; the early birds treat of hearing Mary Liz Bayer with her wonderful imitation of the "bungay" Red River accent, recalling yarns of the early days of the Red River Valley; and the hospitality of the members of the Dietetic Association of Manitoba—all made a lasting impression on the visitors.

The three-day session was opened at the Exhibitors' Luncheon when H. Brock Smith, speaking for the Better Business Bureau, asked us to remember the slogans "investigate before you invest" and "read before you sign". Dr. L. B. Pett, chief of the nutrition division, department of National Health and Welfare, Ottawa, spoke on the possibility of revising the Canadian dietary standard. He emphasized that we must think in terms of health, not of growth. More is not synonymous with health, though our current dietary standard fails to recognize this. To support this statement are the facts that more calories may lead to obesity, more fat may lead to arteriosclerosis. Interest has been diverted from the full physiological understanding of the micro-nutrients protein, fat, and carbohydrate. Also, we as dietitians tend to think too much in terms of precise numbers when we are working with the dietary standard rather than in terms of needs for groups of people. A dietary standard is an attempt to show how far knowledge has gone in describing the amount of nutrients needed for various purposes. These figures should be treated only as guideposts, remembering that because of specific conditions an individual might get all the nutrients, and be malnourished, while another might be well nourished on half the quantity.

Other reports of current interest in the fields of nutrition and diet therapy included a paper presented by Dr. Wallace Grant. Phenylketonuria, an inborn error of metabolism, is thought to be due to the absence of the enzyme system involved in changing the

Miss Benedict is director of dietary services at the New Mount Sinai Hospital, Toronto, Ontario.

24th C. D. A. Convention

Horizons Unlimited

Joan M. Benedict
Toronto, Ont.

amino acid phenylalanine to tyrosine. Infants who have inherited the condition suffer extensive brain damage unless dietary treatment is begun at an early age, preferably before six weeks. The condition may be diagnosed by routine urinalysis for pyruvic acid. The only way to find the condition is to test the urine of all infants when they are a few days old. Phenylketonuria is an inherited factor—a Mendelian recessive gene carried by about one percent of the population. Siblings of the sufferers should be closely checked. The first report of treatment for phenylketonuria occurred five years ago and consisted of regular administration of a diet low in phenylalanine content, but sufficient in all other nutrients to ward off malnutrition. Milk formula preparations which are phenylalanine free casein hydrolysates, are now available. There has not been a sufficient history of the treatment to indicate how long children must be kept on this diet, but evidence has shown that there may be marked improvement in the child who has been diagnosed and treated at an early enough age.

Dr. Jane Leichsenring, of the University of Minnesota, is carrying out research in protein nutrition. The major nutritional problem of the world is an inadequate supply of high quality protein. Vegetable proteins, at the present time, feed two-thirds of the world. As the population increases we must find ways of increasing the quantity and quality of proteins. This may be worked on in several ways; by supplementing the pro-

teins lacking in some essential amino acids by the addition of small amounts of animal protein; by providing the specific amino acids lacking; and by a combination of the other two methods. However, a great deal of experimental work must still be done before we undertake supplementation of amino acids in food supplies.

Dr. Leichsenring reported also on current studies being carried on which deal with arteriosclerosis in relation to diet. Although reduction in serum cholesterol levels does not result entirely from a reduction of cholesterol in the diet, there is sufficient evidence to indicate that the depositing of cholesterol in the blood vessels can be reversed by changing dietary factors. She recommended that we teach moderation in the ingestion of dietary fats, bearing in mind the health hazards of overeating and overweight.

A panel discussion on the subject of recruitment was entitled "Wanted—More Dietitians". We must instill in others our pride and interest in our work. Why should the work of 1,200 professional women be so little known by the Canadian public when that work affects the daily lives of every member of society? The profession of dietetics offers work with a purpose and a challenge. We should point out our pride of accomplishment and the tremendous job satisfaction from our work to the general public, to our personal public, and to those who are advising our Canadian children on future job opportunities.

To meet the present demands, the dietitian must use her talents and training for over-all organization and delegate duties requiring no specialized education to well-trained supervisors. Margaret Gillam of Michigan State University suggests that the dietitian concentrate on policy making, organization planning, directing, and co-ordinating the work of others, to enable her to function

(concluded on page 83)

Food Service

sponsored by the

Canadian Dietetic Association

With the Auxiliaries

A Ray of Sunshine

The patients' days are brighter at the General and Marine Hospital in Collingwood because of the Sunshine Cart operated by the women's auxiliary. Every Tuesday and Friday afternoon, the cart, laden with treats and with small but necessary items, is pushed through the hospital wards. It has been most successful in its first year of life.

This is just one of many interesting projects undertaken by the ladies of the hospital. Their sewers have contributed over 16,000 articles to the General and Marine. Included in the equipment donated to the hospital are a table, lamp and new type of bassinet for the obstetrical department, bassinet table with taps, suction machine for the operating room, gas machine and oxygen tent. Jenny Watts, president of the Hospital Helpers in 1892, began a fine record of service. The present auxiliary, organized in 1945, carries on this service, offering time and energy to the hospital and bringing cheering rays of sunshine to the patients.

Strawberry Festival

Rain may have driven everyone inside, but it failed to dampen the mood when the auxiliary of the Guelph General Hospital, Guelph, Ont., held its annual

strawberry festival. The event was a success in spite of the weather.

A bake table, laden with cakes, cookies, pies and other treats, drew many customers. Tea cup reading, something new this year, pleased many of the people and will probably be carried on at future festivals. Other attractions were a large penny table, a treasure shop, a fish pond and a candy booth. At refreshment time, visitors were served luscious strawberries and ice cream. They were happy and so were the auxiliary members who had turned the strawberry festival into the money needed to carry out their good works.

Come to the Country Fair

Brightly decorated booths were just one of many attractions at the country fair sponsored by the auxiliary of the Metropolitan General Hospital in Windsor, Ont. There was a gift box offering fascinating articles to everyone. There was a fish pond decorated with someone's interpretation of glamorous underwater creatures. There was a sweet tooth booth, offering fudge, popcorn balls and surprise packages.

Visitors, among them many of the hospital's nurses, listened to organ music as they browsed among the booths. They could

buy quilts or aprons, slippers or place mats. And everything they bought will mean some new piece of equipment, some new article of furniture for the hospital.

Superfluity Shop

The auxiliary of the White Rock District Hospital, White Rock, B.C., has opened a new Superfluity Shop. The auxiliary bought a piece of property and had the shop built on it. Thus the opening marked an exciting, new venture for the ladies. The shop will now attract many people who would never go inside the hospital and sales are sure to rise.

The Coffee Cup

The women's auxiliary of the Lachine General Hospital, Montreal, Que., has opened a snack bar and gift shop. They believe that "The Coffee Cup" will add to the comfort of patients and visitors. About 75 women take time from their household chores to come to the hospital and help out in the snack bar.

Perhaps "The Coffee Cup" will serve as a meeting place for friends and relatives waiting in the hospital and for patients who are not confined to their rooms. It promises to be a very successful project.

Garden Party Glamour

Attracted by music drifting across the campus of Queen's University, crowds of people came to the gala garden party held by the auxiliary of Kingston General Hospital, Kingston, Ont. They were greeted by gaily decorated tables offering home baking, bread and buns, candy and aprons. Children were amused at the entertainment centre—really a baby sitting service. And the auxiliary members themselves displayed attractive outfits and dazzling smiles.

One of the most interesting sections at the party was a doll display, presented by the women of the Gananoque Branch. There were dolls of every shape and size in suitable costume. There was also a special hat bar for dolls where little girls could pick out a smart Paris creation for their favourite.

Of course, when visitors grew tired of walking from booth to booth they were invited to go inside for tea. Then, refreshed, they continued on their way, gazing with delighted eyes on the many treats this garden party offered. ■



Photo by D. O. Deacon, Collingwood

Two of the "Sunshine gals" at work.

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Notes on Federal Grants

Construction

A new 34-bed hospital — the Wilkie Union Hospital—in Wilkie, Sask., is to receive \$80,893 to help with construction costs. The hospital will also have nine bassinets and related hospital facilities such as x-ray, laboratory and treatment areas. The existing hospital will be converted to a home for the aged and a portion to a nursing home.

Vegreville General Hospital, Vegreville, Alta., has been awarded \$44,250 to assist in building a new nurses' residence and school, which will provide teaching facilities and accommodation for 59 nurses. It is hoped that the residence will be ready by October.

A grant of \$146,933 will aid the construction of the Toronto Rehabilitation Centre. The centre, formerly known as the Toronto Association of Occupational Therapy, will provide complete rehabilitation facilities on an out-patient basis to residents of the Toronto area.

A new maternity wing will be built on the Englehart and District hospital at Englehart, Ont., with the aid of \$34,666 from the federal government. Here will be housed 14 patients' beds and ten bassinets.

Modern living accommodation for the staff of the new Manitouwadge General Hospital, Manitouwadge, Ont., will be provided in a new 11-bed nurses' residence to be built with the assistance of \$8,250 from the federal government.

A major renovation project at the Saint John General Hospital, Saint John, N.B., will receive \$33,333 in a grant. A modern efficient x-ray diagnostic unit capable of serving double the bed capacity of the present hospital is included in the program, along with expansion to bring the hospital's capacity up to 591 beds, 86 bassinets and out-patient facilities.

A grant of \$37,000 goes to the Psychopathic Hospital, Winnipeg, Man., for renovation work to improve office and diagnostic space.

The Bella Coola General Hospital, Bella Coola, B.C., will be helped by a \$9,750 grant in construction a new 13-bed nurses' residence.

Some \$9,000 goes to the Kootenay Lake General Hospital, Nelson B.C., to aid the building of a new 12-bed nurses' residence.

A new 568-bed unit for the Ontario Hospital, Woodstock, Ont., has been scheduled to expand the accommodation for epileptics and mentally ill persons with tuberculosis in Ontario. The project, part of the chest diseases division will receive \$915,947 from the federal government, and when completed, will bring the hospital's total bed capacity to more than 1,800.

The Charlotte Eleanor Englehart Hospital, Petrolia, Ont., has been given \$109,333 toward the construction costs of a section to hold 46 active treatment beds, 13 bassinets and training facilities. Renovation of a dining room and kitchen into space for an x-ray department and laboratory is also included in the hospital's plans.

Additional gynaecology department space for Toronto Western Hospital, Toronto, Ont., will be made available when construction plans have been carried out there. A grant of \$4,653 has been allotted.

At Shawville, Que., the Pontiac Community Hospital plans construction of an 11-bed nurses' residence with the aid of a \$8,250 grant.

A grant of \$37,333 has been made to the Hôtel-Dieu de Montréal, Montreal, Que.

Some \$39,330 has been allotted to the Welland County General Hospital at Welland, Ont., to help in the building of a community health centre. The centre will provide headquarters for a medical officer, public health nurses, and sanitary inspectors as well as clinic facilities for either the hospital or the Welland and District Health Unit.

A new nurses' residence and school of nursing for the Archer Memorial Hospital, Lamont, Alta., will be helped by a \$53,250 grant. The new building will house 71 nurses' beds, lounges, library, class rooms, demonstration room, science and diet laboratories, gym, laundry and recreation rooms.

Red Deer Municipal Hospital, Red Deer, Alta., has been allotted \$130,166 to go towards the con-

struction of a new wing — a house 101 beds and 11 bassinets — and for a new nurses' residence as well. The residence will have room for 51 staff members.

Some 11 more beds and eight bassinets will be added to the Rimbey Municipal Hospital, Rimbey, Alta. A grant of \$14,333 from the federal government will aid the construction of the new wing in which a new isolation suite, a paediatric ward and a morgue are to be built.

The Riverdale Hospital, Rivers, Man., has been allotted \$74,416 to help build a 20-bed, ten bassinet building. A delivery room, a labour bed, major and minor operating rooms and a central sterilization area will be included too. Offices for public health workers, dentists, doctors and x-ray and laboratory departments have also been incorporated into the plans.

A grant of \$201,243 has been made available to St. Joseph's Hospital, Chatham, Ont. The hospital is planning a new addition which will house 87 more active treatment beds and 15 nurses' beds.

For renovation to convert intern's quarters to laboratories and classrooms, on the second and third floors of the Hamilton General Hospital, Hamilton, Ont., the hospital has been awarded \$13,333.

The Riverdale Hospital, Toronto, Ont., will receive \$98,633 for renovation of its existing Hastings building, a former isolation hospital. The changes will make available 66 beds for the chronically ill.

To help provide hospital facilities for the rapidly growing area in the east of Metropolitan Toronto, a grant of \$432,210 has been made for the Scarborough General Hospital. A new addition, scheduled for completion by early 1960, is to house 172 beds, 42 bassinets, three nurses' beds and a new out-patient department.

Diagnosis and Research

A grant amounting to \$20,410 will assist Hôpital Lourdes du Blanc Sablon, Blanc Sablon, Que., to purchase a new x-ray machine.

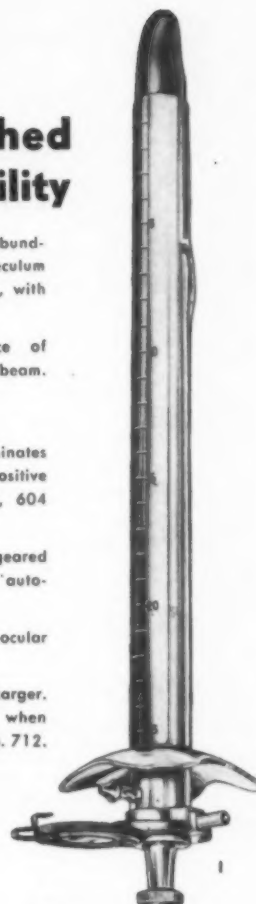
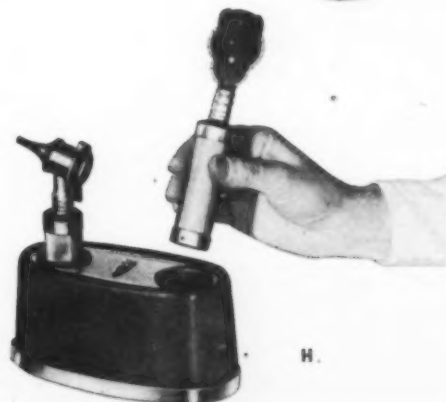
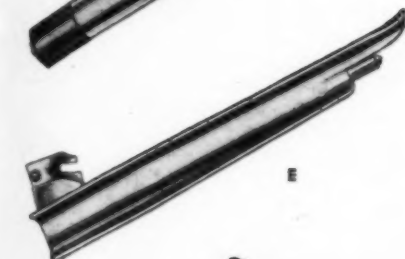
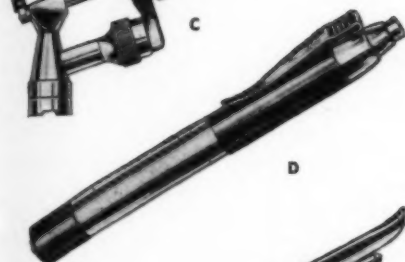
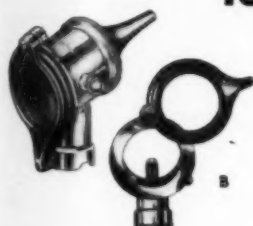
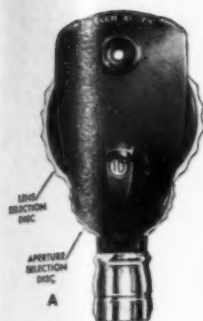
A crippled children's grant of \$17,830 will help support the development of a rehabilitation centre for crippled children in the Three Rivers area. This centre, le Centre de Réhabilitation de la Vallée du Saint-Maurice, was organized in 1954 by the Quebec Society for Crippled Children and was first run by that society. Since the first of this year it has

(concluded on page 85)

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Hospital on Top of the World

In Peru, a new 250-bed general hospital has been built high in the mountains in Tarma—10,500 feet above sea level. The town, 156 miles from Lima is approachable only by a long tortuous road, and has a population of 20,000. Since May 1958 these inhabitants boast of the most modern hospital in Peru—built in only two years and designed by Peruvian architects but equipped completely by a German firm. Here altitude proved a difficult factor in the construction. Road and rail conditions meant repeated loading and unloading of goods disembarked in the harbour of Callao. Special vehicles had to transport the heavy goods. Experts were sent over from Germany for installing the equipment, and, in fact, had to contribute to the construction itself since the arrival of the various apparatus and machinery had to be carefully co-ordinated with the progress of the building. Tarma, too, is the first hospital in Peru to be equipped with central heating—because of its altitude. The heat values for the installation had to be worked out in Germany and radiators supplied from there, since Peruvians had no experience in calculations of this kind.

The hospital is a reinforced concrete shell supporting one basement floor and six storeys. Patient beds number 250 and there is a large out-patient department as well as quarters for the doctors, nurses, garages, and workshops. Three wings, which differ in height and length, extend backwards from the main block. The irregularity of these wings is a result of their having been adapted to their respective purposes. The centre wing contains the treatment sections and kitchen plus the x-ray and physiotherapy departments and a small casualty ward. Laboratories, gynaecological operating and treatment rooms, paediatric division, operating room suites, and surgical wards are included in the main block too. Wards for pulmonary diseases and other special fields are housed in

the fifth storey of the main block but have no connection with it at this level.

The right annex, a single-storey building with no basement, has the out-patient, department and specialists' examination and treatment rooms and is also used for specialist treatment of in-patients. Here, too, is a mothers' advisory service, a child welfare department and a mass chest x-ray unit. The left wing has workshops, conference room, some administration rooms which connect with the main block's administration section.—*Hospital and Health Management.*

In Nebraska, a Retirement Village

On the outskirts of Hasting, Nebraska, U.S.A., a town specifically designed for older people is being built. Called the "Good Samaritan Village", this colony offers a complete retirement service; consisting of one- to three-bedroom apartments for couples or individuals who are self-sustaining, and who require merely the companionship of others in their age group. Similar apartments for those who can maintain their own households with assistance from a "house visitor" who will drop in each day to help with household duties and meal planning will be available too. There are also the same living arrangements for residents who want to take one or more meals in a central dining room. A centrally located Rest Home will provide personal care under medical supervision for those who can no longer maintain their own apartments, or who need help with feeding, dressing or walking. An infirmary section in the Rest Home is also under medical supervision for those in need of skilled nursing care.—*Chronic Illness Newsletter.*

On a Norwegian Hill

The newly erected Recreation Home for War Invalids in Kongsvinger, Norway, has a strange history. It began years ago when Emperor Haile Selassie of Ethiopia wanted to present money to the children of Norwegian war dead. But before the Emperor had

an opportunity of visiting Norway, the children had grown up. It was then that the president and secretary general of the Norwegian War Invalids Association submitted the idea of a recreation home. Both Haile Selassie and the Norwegian government agreed, and an architect, F. S. Platou agreed to work without payment, but more money had to be found. And it was—through fund raising, sale of badges, contributions from local authorities and the government, proceeds from the film "Nine Lives", an important loan from a bank. The World Veterans' Foundation and the Danish veterans provided furniture for the public rooms, and a Norwegian veteran bequeathed his library.

Within a year the home was completed. Now it is a true home for war disabled persons and their families—24 people in all.—*World Veteran.*

Holland's "Hospital Centre"

The "Bouwcentrum" (Building Centre) in Rotterdam, Netherlands, now has a special "Hospital Centre", which serves as a permanent information and exhibition centre for hospital planning and equipment. Here are gathered together the results of many years' research, produced in tangible form. As investigation and research continue, these displays and models will be modified so that they will always be up-to-date and expressive of lines of thought, not only in the Netherlands, but in various other countries as well. There is a full-scale mock-up of a three-bed ward with all the necessary equipment, such as bedside lockers, over-bed tables, cubicle curtains, and piped oxygen. Other exhibits cover all types of equipment—for operating theatres, kitchens, laboratories. Different types of flooring, call systems and heating systems are also on view.

A most interesting section is the design part. This includes small-scale models of recent hospitals and a model of a ward unit and of an x-ray department. Perhaps the most interesting item in the whole exhibition is the room for experiments in design and lay-out. Here a large table is divided into squares so that scale models may be put together using the wall sections provided. All kinds of hospital equipment are also available so that new lay-outs of wards and other departments may be tried out.—*I.H.F. News Bulletin.*

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Unions and You

(concluded from page 41)

employees, the status of our labour legislation and the size and power of the unions will ensure that that hospital staff is organized.

In our democratic society, the one prerequisite for union organization, or almost any type of organization for that matter, is that the employees must wish to organize. Therefore, perhaps the only effective method to keep a union out of one's hospital is to make the working conditions so good and to develop loyalty in the staff so much that the employees will feel no need or desire to form a union. However, in doing this, you will have achieved the aims of any responsible union group.

2. Every administrator should try to familiarize himself with some of the history of trade unionism and with modern union organization. This includes a working knowledge of modern terminology and of legislation; e.g. arbitration, conciliation, the Hours of Work Act, union shop, closed shop and a host of others. The administrator cannot hope to work effectively

either with, or against a union unless he knows something about it.

3. Every administrator should learn something at least about methods of collective bargaining and negotiation. The administrator cannot hope to give himself or his hospital an even chance in union negotiations if he is uninformed and unprepared to sit across the table from skilled and intelligent people who make union organization and collective bargaining their life's work.

4. The "golden rule" has always been, and I hope will always be, a good guiding principle. If one fights tooth and nail to prevent a union from organizing the employees; if one is unco-operative; if one treats another without courtesy and respect; one should not be surprised to receive similar treatment in return. I do not mean by this that any representative of management should take a "soft" attitude toward union negotiators. Most of us respect the weakling no more, or perhaps even less, than we do the unreasonable tyrant. Naturally, the administrator will have to adopt tactics suitable to the situation. The union

organizers are not necessarily saints, neither are they necessarily devils. I believe that the majority of union organizers, like any other group, will respect and respond to firmness and fair play.

5. When a union comes to the hospital, I believe that it should be welcomed and encouraged for all of the foregoing reasons and, additionally, because it is anyone's right to organize if he wishes to do so. Hospitals have their associations; administrators, doctors and others have their colleges; lawyers have their bar associations; indeed, most of us have and cherish the right to join vocational organizations. I believe that unions still have a long way to go in developing educational and other more altruistic activities to counter-balance demands for more money, shorter hours and other benefits. I also believe that we will not discourage the more militant side of their endeavours nor encourage activities on a higher plane by adopting a militant attitude ourselves.

6. Thus it becomes one of the most important parts of the administrator's rôle to promote a healthy union interest in the problems of management and in the objectives of the enterprise. The administrator is strongly obligated to provide good education in these subjects both to the union officials and organizers and to all members of the hospital staff, including those who are also members of the union.

7. It is the administrator's duty to promote common understanding between labour and management on their common goals, their mutual interests, and, also, their individual needs.

Although we remember the beginnings of unions in terms of strife and bloodshed, unions are nonetheless here to stay. Happily, there are many signs that unions are becoming more mature and responsible in their beliefs and in their activities. Not only because the administrator cannot possibly keep them out, but, more important, because the union can be a great force for good, the administrator's rôle calls for understanding, co-operation and leadership. Unions can, and should, encourage their members to work to maintain and to improve the objectives of their enterprise. The administrator can, and should, do all in his power to foster and encourage this type of union activity. ■

Coming Conventions

Aug. 23-26—American College of Hospital Administrators, 25th annual meeting and convocation, Statler Hotel, New York City.

Aug. 24-27—American Hospital Association, annual convention, Coliseum, Statler Hotel, New York City, N.Y.

Sept. 6-12—World Confederation for Physical Therapy, 3rd international congress, Paris, France.

Sept. 8-11—Canadian Association of Medical Record Librarians, annual convention, Royal Alexandra Hotel, Winnipeg, Man.

Sept. 8-12—Western Canada Institute, Royal Alexandra Hotel, Winnipeg, Manitoba.

Sept. 22-23—Catholic Hospital Conference of Alberta, 16th annual meeting, Corona Hotel, Edmonton, Alta.

Sept. 28-Oct. 2—American College of Surgeons, 45th annual clinical congress, Convention Hall, Atlantic City, New Jersey.

Oct. 14-16—Saskatchewan Hospital Association, annual meeting and convention, Bessborough Hotel, Saskatoon, Sask.

Oct. 17—Catholic Hospital Conference of Saskatchewan, annual meeting, Bessborough Hotel, Saskatoon, Sask.

Oct. 18-19—Catholic Hospital Conference of British Columbia, annual convention, Vancouver, B.C.

Oct. 20-23—British Columbia Hospitals' Association, annual convention, Hotel Vancouver, Vancouver, B.C.

Oct. 21-23—Conference on Cerebral Palsy, sponsored by the Cerebral Palsy Association of Quebec, Inc., 10th anniversary conference, Montreal, Que.

Oct. 26-28—Ontario Hospital Association, annual convention, Royal York Hotel, Toronto, Ont.

Oct. 27-29—Associated Hospitals of Alberta, annual convention, Jubilee Auditorium, Edmonton, Alta.

Oct. 29-30—Ontario Conference of the Catholic Hospital Association, St. Michael's Hospital, Toronto, Ont.

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Book Reviews

THE BOOK OF pH, by R. B. Webber, M.A. (Cantab.) Published by George Newnes Limited, London, Eng. Distributed in Canada by Brett-Macmillan Ltd., Galt, Ont. Illus. Pp. 111. Price \$6.00.

In this book the pH scale, a series of numbers that measure the acidity or alkalinity of an aqueous solution, is defined in the simplest possible terms. Early sections of the book have been devoted to the essential pH theory and the importance of pH in many forms of industry.

Other valuable divisions cover the colorimetric method of pH measurement, electrical methods of measurement and additional details about the meaning of pH. There is also a section on acidity and non-aqueous solutions. The explanations are made much more vivid by a number of illustrations, some of which are in colour.

MEDICAL LABORATORY INVESTIGATIONS, Their Use and Interpretation. By Ian Dawson, M.A., M.D., M.R.C.P. and William Goldie, M.A., M.B., F.R.C.P., F.R.C.P.(E). Published by Butterworth and Company (Canada) Ltd., Toronto, Ont., 1958. Pp. 260. Price \$7.00.

This is what the authors say about their book: "The purpose of this book is to provide the clinician, the family doctor, the registrar and the house physician or surgeon and the medical student with information about which laboratory investigations will help them most, what sort of material the laboratory needs, how accurate the investigations are, what the principal sources of error are and what the results mean. It is intended as a handy source of information . . ."

MEDICAL AND SURGICAL NURSING II, by Amy Frances Brown, R.N., B.Ed., M.S. in N., Ph.D. Published by the W. B. Saunders Company, Philadelphia, Pa. 1959. Price about \$8.25 (U.S.A.) Charts Illus. Pp. 850.

This volume covers the clinical essentials in nursing care of adult medical and surgical patients. It is intended to help instructors in providing textbook materials for students, and will eventually become volume II in a set of two books on integrated medical and surgical nursing.

The author has emphasized nursing care, spiritual needs of patients, historical sketches, psychological aspects and rehabilitation. Drug therapy is dealt with throughout, and numerous teaching aids and illustrations are provided. Miss Brown has incorporated also valuable information on mass casualties, communicable disease, management of wounds contaminated with radioactive isotopes, ventilatory resuscitation and hypovolemic shock, to mention only a few. The work throughout carries the author's convictions, gleaned from her own impressive teaching and clinical experience, on the selection and organization of learning experiences for students.

THE SCHOOL HEALTH PROGRAM, by Alma Nemir, M.D. Published by the W. B. Saunders Company, Philadelphia and London, 1959. Pp. 428. Illus. Price \$6.00.

This book was written for teachers—to help them detect and look after the health problems of their students. The first part describes a child's normal development. Then it goes on to discuss the most common illnesses of school children, telling how to recognize the symptoms and what to do about them.

The second section of the book is devoted to the school health program. It tells how such a program can be organized and run. All in all, this is an extremely valuable volume for teachers, who can be, as the author points out, "our first line of defense in the school health program."

THE MEDICAL SECRETARY by Kenneth B. Coffin and R. Forrest Colwell. Published by the Macmillan Company, New York, 1959. In Canada by Brett-Macmillan Ltd., Galt, Ont. Pp. 391. Price \$5.95.

This is a textbook for the medical secretary—in a medical, hospital or dental office. It gives the usual instructions on handling the patients, personal appearance and telephone etiquette. It also offers more specific information, such as how to process health insurance claims and how to fill out medical forms.

The book is divided into lessons; each lesson ends with a list of

common medical terms plus review questions on the material covered. Also included are several sample letters which give the secretary a chance to learn the format of the letters which are most frequently written by doctors and dentists.

THE FAMILY MEDICAL ENCYCLOPEDIA, by Justus J. Schifferes, Ph. D. Published by Little, Brown and Company, Boston and Toronto, 1959. Pp. 617. Price \$4.95.

This is a small, compact reference book which gives a list of medical terms all the way from abasia to zymurgy. Each is accompanied by a brief explanation.

FUNDAMENTALS IN NURSING CARE, by Mildred L. Montag, Ed.D., R.N. and Ruth P. Stewart Swenson, M.A., R.N. Third Edition. Published by the W. B. Saunders Co., Philadelphia and London, 1959. Illus. Pp. 581. Price \$5.00.

This is the third edition of a book previously titled *Nursing Arts*. Its chapters have been reorganized to give the care of the patients first consideration, for it is felt that the student should learn about people before things. There have been changes, too, within the chapters—specific nursing procedures have been omitted in favour of general principles. Bibliographies have also been revised and the number of illustrations has been increased. The authors themselves claim that in preparing this edition they were always guided by a question—What does the nurse need to know in order to give good nursing care?

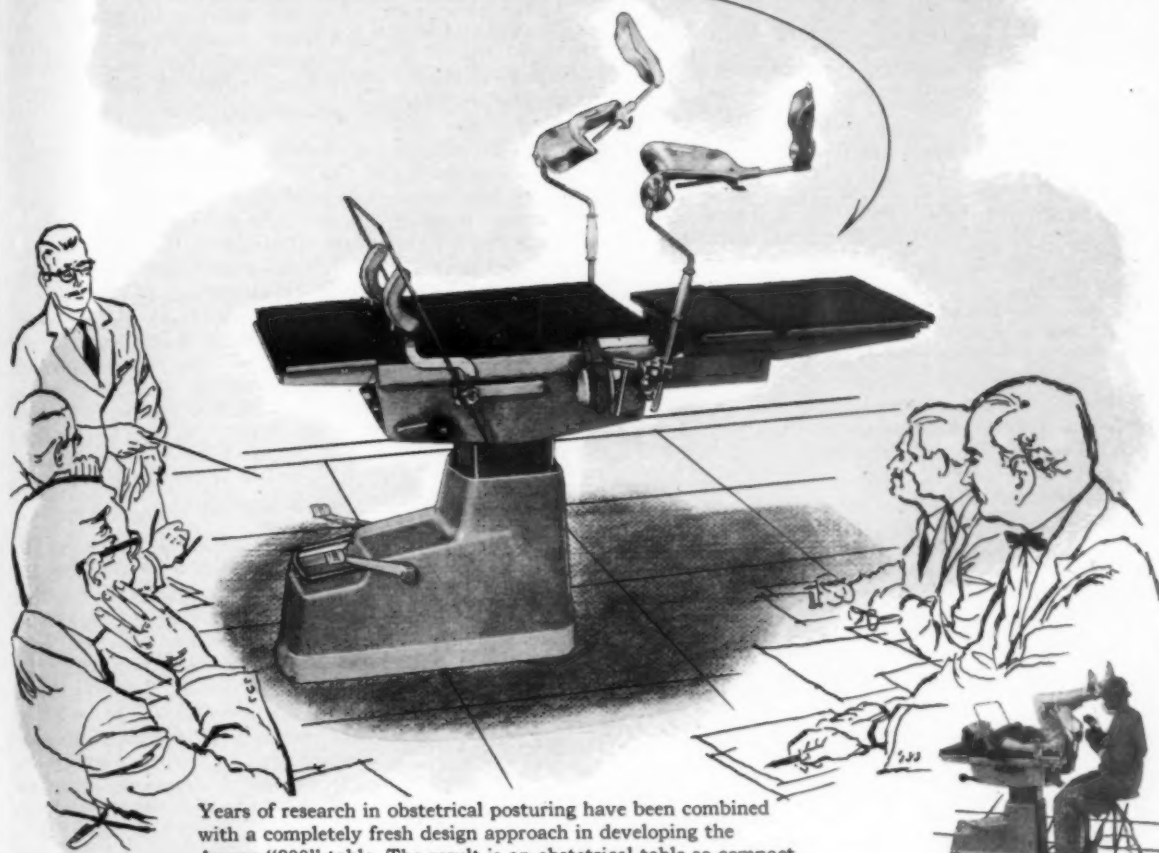
THE ART, SCIENCE AND SPIRIT OF NURSING, by Alice L. Price, R.N., M.A. Published by the W. B. Saunders Co., Philadelphia and London, 1959. Second Edition. Illus. Pp. 864. Price \$5.50.

This is a book which emphasizes principles rather than procedures. Therefore it offers useful fundamental knowledge to the student nurse and helps prepare her for the many situations she will encounter. Changes in the second edition include the addition of material on nursing in the recovery room and intensive care unit, as well as chapters on asepsis and radiation therapy.

CURRENT DRUG HANDBOOK 1959-60 by Mary W. Falconer, R.N., M.A. and H. Robert Patterson, B.S., M.S., Pharm. D. Published by the W. B. Saunders Co., Philadelphia and London, 1959. Pp. 161. Price \$2.75.

This handbook offers information on about 1,000 drugs which
(concluded on page 68)

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Book Reviews

(concluded from page 66)

are used today. Small and compact, set up in tables, it is intended for quick reference and supplements material in standard textbooks. The manual presents the data clearly for it has been well planned. Drugs are listed according to type, a system which permits quick comparisons. And a complete index enables the reader to find the information on any drug within seconds.

A TEXTBOOK OF PHARMACOLOGY AND THERAPEUTICS, by Harold N. Wright, M.S., Ph.D., and Mildred Montag, Ed.D., R.N. Published by the W. B. Saunders Co., Philadelphia and London, 1959. Seventh Edition. Illus. Pp. 497. Price \$5.00.

Revisions in the seventh edition of this book bring it up to date with recent advances in the fields of pharmacology and therapeutics and make it even more useful. Much practical information is presented here in a very attractive and very clear format. This is a valuable textbook indeed.

The book also contains an appendix on Canadian Drug Legislation by Charles W. Nash, B.Sc., Ph.D., professor of pharmacology, faculty of medicine, University of Alberta, Edmonton.

HUMAN RELATIONS IN NURSING—A Textbook in Sociology, by Wayland J. Hayes, Ph.D., and Rena Gazaway, R.N., B.S.P.H.N., M.A. Published by the W. B. Saunders Co., Philadelphia and London, 1959. Second edition, Illus. Pp. 486. Price \$5.25.

Student nurses must learn to look objectively at their society, to realize its workings and to analyze social systems. This book has been designed to help them. Then they will gain deeper insight into the human relationships involved in their service.

The second edition brings material up-to-date, adding a chapter on population and one on population problems.

NURSING OF CHILDREN, by Robert A. Lyon, M.D. and Elgie M. Wallinger, R.N., B.S., M.A. Published by the W. B. Saunders Co., Philadelphia and London, 1959. Fifth edition. Illus. Pp. 554. Price \$5.00.

From this book the nurse can learn, first of all, about the normal child, his patterns of growth and his behaviour. Only then is she led into a consideration of the illnesses of children that disturb them physically and psychologically. She is told how to meet these illnesses with scientific skill.

But she must have something more than that. For in the special care of children there is loving kindness as well as treatment.

TRENDS IN NURSING HISTORY, by Elizabeth M. Jamieson, R.N., B.A., Mary F. Sewall, R.N., B.S. and Lucille S. Gjertson, R.N., B.S., M.A. Published by the W. B. Saunders Co., Philadelphia and London, 1959. Fifth Edition. Illus. Pp. 522. Price \$5.00.

From "Life Among Primitive Peoples", the first chapter, to "Modern Nursing Careers", the last, this book is designed to tell the story of nursing. Knowledge of the ideals and principles belonging to those who helped make nursing what it is today is, after all, "the rightful inheritance of all nurses". By reading this book the nurse can see and understand her rôle in the progress of society.

CHILDBIRTH WITHOUT PAIN, by Dr. Pierre Vellay and others. Published by George Allen and Unwin Limited, London, England, 1959. Pp. 216. Price 35s (about \$5.00)

The system described in this book, a system which promises *painless* and satisfying childbirth, is based on discoveries made by the Russian scientist Pavlov. It was evolved by the late Dr. Fernand Lamaze. This book is written by his disciple.

The mother-to-be is taught to understand the process of childbirth and to control it. To do this she must have the proper training and she must have help and encouragement from her doctor, from his assistant (who helps the mother during pregnancy and delivery) and from her husband. When her child is ready to be born, she will be ready to do her job. For childbirth without pain, stresses the author, does not mean childbirth without effort.

This is an encouraging book, containing letters from many women who have used the method and who have found great joy in it. One can only hope that Dr. Vellay's message will not go unheeded in North America.

REHABILITATION CENTER PLANNING, an Architectural Guide. By F. Cuthbert Salmon, A.I.A. and Christine F. Salmon, A.I.A. Published by the Pennsylvania State University Press, University Park, Pa., 1959. Pp. 164. Price \$12.50.

Well illustrated and attractive, this book has been designed to help architects understand the problem of rehabilitation. Then they can help solve the problem with effective planning of rehabilitation

centres. No single plan is emphasized, for the book makes it clear that each rehabilitation unit is different, requiring its own special lay-out and equipment.

Twenty-eight rehabilitation centres in the United States and Canada were studied and other plans and programs were analyzed to provide background material. Architectural conclusions were drawn from observations and from discussions with staff and patients at various institutions.

Rehabilitation Services in Canada

Part II of the publication on the rehabilitation services in Canada, put out by the Research and Statistics Division of the Department of National Health and Welfare, under the authorization of the Hon. J. Waldo Monteith, is now available. This 222-page reference lists and explains all the provincial and local programs pertaining to rehabilitation in Canada up to February, 1959. It can be obtained from Ottawa as memorandum No. 9, of the federal government's Health Care Series.

To Help the Practical Nurse

The Committee on Careers, National League for Nursing, New York, has issued an interesting and useful booklet entitled "Let's Be Practical about a Nursing Career". The booklet contains career guidance information and a list of the schools of practical nursing which have been approved by state boards of nursing throughout the United States. It tells what the career opportunities for a practical nurse are—in hospitals, private practice, public health agencies, doctors' offices and the civil service. It also lists the qualities and qualifications the successful practical nurse must have.

Copies of the booklet may be obtained from the Committee on Careers, National League for Nursing, 10 Columbus Circle, New York 19, N.Y. Single copies are free; 100 copies cost \$9.00, 500 copies, \$40.

Promoter of Thought

Perhaps the highest use of books is not as sources of information about nations, people, or foreign lands, but as friends. Reading is one of the most effective means of getting away from disturbing and unalterable circumstances. Intimate association with noble works, literary, philosophic, artistic, is a promoter of thought.—*Monthly Letter*.

Of Special Interest to Advertisers

We are often asked: How does the Canadian Hospital Association, and its journal, *Canadian Hospital*, serve the hospital field, readers and advertisers? Here are some of the answers.

Charles A. Edwards

THE Canadian Hospital Association is the federation of provincial and regional hospital associations, Catholic conferences, and the Canadian Medical Association, co-operating with the federal and provincial governments and voluntary non-profit organizations in the health field.

How are we financed?

The hospitals in each province support their provincial associations. The latter in turn make grants, based on bed capacity, to the Canadian Hospital Association. In addition, the Sun Life Assurance Company of Canada has, since our inception, contributed substantially to our funds for general purposes; and the W. K. Kellogg Foundation has for many years generously supported our educational programs. The Canadian Council of Blue Cross Plans has also contributed to our work for a number of years. Surpluses from the operation of our publications are also used in the promotion of various association activities.

Educational programs

Hospital Organization and Management is the title of an extension course conducted by the association. Each year some 80 students, representing hospitals from coast to coast, enrol for the two-year program. Courses are conducted by mail and supplemented by summer-school training in a central place. Thus senior hospital personnel are enabled to qualify for more responsible positions in hospital administration. Another popular extension course is that offered to medical record librarians — a type of training which is in great demand.

Our association maintains an extensive library of hospital literature. Hospital people may borrow package libraries on a three-week basis without charge. An information service is also provided to give data on construction and hospital procedures.

Accreditation

The Canadian Hospital Association is, of course, a constituent member of the Canadian Council on Hospital Accreditation. In this project we are associated with the Canadian Medical Association, The Royal College of Physicians and Surgeons of Canada, and l'Association des Médecins de langue française du Canada. The accreditation program is one of the most useful instruments yet devised for improving hospital care.

Directory

Each spring we publish the *Canadian Hospital Directory*. This publication serves many useful purposes: it provides a complete list of hospitals in

Canada, maps showing location of towns and cities, names of key personnel, bed capacity, budget and admissions; tables showing bed distribution; detailed information on educational programs for hospital personnel; listings of hospital associations and allied organizations; and a buyers' directory of equipment and supplies. This year, as in 1957, it also has a section on hospital construction. Much of the information contained in the directory can not be found elsewhere.

Canadian Hospital

The journal of the association, *Canadian Hospital*, belongs to the hospital people of Canada. It is the medium through which they can share their ideas on all phases of hospital service. In it they read articles by authorities in the field, news, and editorial discussion of current topics. Each month *Canadian Hospital* features at least one new hospital lay-out. One of our regular columns is devoted to the work of the women's hospital auxiliaries, and one article each month is sponsored by the Canadian Dietetic Association. Articles of special interest to particular departments appear frequently, and on occasions a whole issue may be devoted to phases of one topic; e.g., construction, hospital insurance, staphylococcal infections, accounting, or nursing. Here, too, readers find effectively illustrated advertisements of the best products available to them, as well as news provided by supply houses.

Our readers encompass all groups who work in and for hospitals—from administrators to department heads, chiefs of medical services and trustees, hospital architects, hospital consultants and engineers. Public libraries and government departments are also among our subscribers.

Canadian Hospital is the most effective and economical medium for the distribution of information by the hospital supply houses. Because many firms have advertised consistently in our columns for up to 35 years, and because the volume of our advertising is constantly increasing, we believe that *Canadian Hospital* enjoys the full confidence and respect of our 250 advertisers. Monthly circulation is approximately 4,100—70 per cent of which is on a paid subscription basis.

The *Canadian Hospital's* large volume of advertising has enabled us to set advertising rates which are lower than those of most other magazines of comparable circulation.

We trust that the foregoing helps to explain to our advertisers some of the objectives and accomplishments of the Canadian Hospital Association and its publications.

Provincial Notes

British Columbia

The contract has been awarded for the construction of a new hospital to replace the Kimberley and District General Hospital, Kimberley. The new hospital will have an initial capacity of 49 beds. A surgical wing of 22 beds will probably not be used until a later date. Facilities for the public health unit will be included in the hospital building and will provide offices for the medical director, two nurses, dentist's office, clinic room and space for private societies.

The new St. Mary's Hospital in New Westminster has been officially opened. The 150-bed building replaces the former hospital which was built in 1886 and which held 63 beds. A "T" shaped, reinforced concrete structure, the hospital has six floors in the top of the T which comprise laundry facilities, diagnostic services, operating rooms and patient accommodation. There is a seventh floor for nurses and staff quarters. In the stem of the T are three floors containing kitchen services, storage areas, administrative offices and patient beds. Architects are Allen C. Smith and Associates, Vancouver.

The sod has been turned for the new St. Joseph's General Hospital to be built in Dawson Creek. The three-storey building will eventually provide 100 beds, but at first will use only 60. At the ceremony, the hospital's administrator read an encouraging telegram from her Sister Superior in Montreal—"You have met the challenge as worthy pioneers of Canada's north west", it said.

The new Valleyview Building, a division of the Home for the Aged in Essondale has been officially opened. The building will accommodate 328 mentally ill patients.

The Vancouver General Hospital, Vancouver, added 504 beds to its total when the ten-storey, \$8,000,000 Centennial Pavilion was opened. There are 27 beds in the emergency section, 18 operating rooms, an ultra modern x-ray machine which can produce prints in six minutes, a mechanized meal tran-

sit system, electrically adjustable beds, and an elaborate inter-communication system which lets patients talk directly with the nurses in the nursing stations.

In a successful fund-raising drive, the Royal Jubilee Hospital in Victoria raised \$425,000. This means the hospital qualifies for government grants totalling \$2,000,000. It is expected therefore that construction of a 190-bed wing will begin soon. Plans by Townley and Matheson, Vancouver, call for a five-storey L-shaped wing.

Alberta

Construction may soon begin on a 175-200 bed convalescent wing for the Calgary General Hospital in Calgary. The actual number of beds will depend on whether a proposed rehabilitation division is approved. Such a division would mean the sacrifice of some beds—but could prove extremely useful.

The original plans for an addition to Edmonton's Royal Alexandra Hospital have been changed. The new building will contain not 300 but 600 beds. This was made possible by the provincial government's decision to contribute to the project. Designed by architects Rule, Wynn and Rule of Edmonton, the extension will cost an estimated \$9,000,000. Tenders will be called in the fall.

The new and modern Bassano Municipal Hospital, Bassano, has been built. The long-awaited hospital offers the most modern equipment available — including closed circuit television conduits and oxygen piped to all wards. It has 30 beds and six bassinets.

Saskatchewan

Plans are now complete and tenders have been called for a two-wing addition to St. Peter's Hospital in Melville. The original plans which called for one wing were scrapped when it was realized that all the services required could not be held in one wing. The hospital will have new kitchen and dining rooms, laundry, boiler room, recovery room, pharmacy, doctors'

room, diet kitchen, store rooms, locker rooms, more space for the x-ray department and laboratory, and a new physiotherapy room. The total number of beds in the hospital will be 80 — 65 of them will be new.

Working drawings are complete and tenders have been called for construction of an extension to the Melfort Union Hospital in Melfort. Plans for the concrete, frame and masonry structure, which will cost an estimated \$325,000, are being prepared by architects Webster, Forrester and Scott, Saskatoon.

The Victoria Union Hospital in Prince Albert expects that its new 74-bed wing will be completed this fall. The cost will be about \$900,000. This marks the beginning of a large expansion program for the hospital, a program which will see many of the hospital's old buildings replaced in the next four years.

The newly-completed \$100,000 wing at the Central Butte Union Hospital in Central Butte has been officially opened and is now in operation. The addition contains offices, two operating rooms, a case room, x-ray laboratory, pharmacy, central sterilizing room, public health offices and doctors' offices. It increases the capacity of the hospital from 18 to 27 beds.

The new 16-bed Gull Lake Union Hospital in Gull Lake has been officially opened. Besides private and semi-private patients' rooms, there are a recovery room and a labour room in the hospital. Designed by Black, Larson, McMillan and Associates, Regina, the one-storey building plus equipment cost approximately \$240,000.

A large crowd came out to the Lucky Lake Union Hospital, Lucky Lake, when the new nurses' residence was opened. The attractive, \$30,000 residence contains six bedrooms, a matron's suite, a large lounge and a well-equipped kitchen.

Manitoba

A ten-bed addition is planned for the Arbog Memorial Hospital in Arbog. Architects are Waisman, Ross and Associates, Winnipeg. They are planning a one-storey extension of frame and stucco for the hospital.

The Morris Hospital District Board has completed plans for an expansion project at its two hospitals in Morris and Emerson—the Morris General Hospital and the
(continued on page 72)



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Provincial Notes
(continued from page 70)

Emerson Hospital. Pressure on the district's hospital facilities has been steadily increasing since 1951 and both hospitals are overcrowded. The expansion plans call for an additional 20 beds and a 16-bed nurses' home at Morris and eight beds plus a six-bed nurses' home at Emerson.

Grace Hospital in Winnipeg has opened a new \$1,300,000 maternity wing containing 60 beds. Besides new delivery rooms the new wing contains an emergency department and enlarged space for laboratories.

Work has begun on an 18-bed addition to the Glenboro Medical Nursing Unit in Glenboro. The architects are Waisman, Ross and Associates, Winnipeg.

Ontario

The Hospital for Sick Children, Toronto, was recently visited by 16 paediatricians from Russia. They all expressed approval. "We liked the whole building and its organization, and specifically the department for premature babies", they said. They remarked that many treatments here are also carried on in Russia—e.g., intravenous therapy in gastro-intestinal diseases. They also noted a similar stress on entertainment and play for young patients. Russia does not have such large institutions as the Hospital for Sick Children. Instead it has numerous small hospitals, and more Soviet children are treated in hospitals than at home.

Work on the new multi-million dollar Ontario Hospital for Retarded Children at Blenheim is proceeding on schedule. The hospital will provide 1,300 beds at first, but will be expanded some time in the future to accommodate 2,200 beds. One building at least is to be ready for occupancy early next year.

Because of the increase in traffic and mine accidents in the uranium town of Elliot Lake, an emergency ward has been opened at St. Joseph's Hospital there. Extra staff has been hired to look after the ward which will provide accommodation for two overnight patients. Construction work on the 116-bed hospital is moving ahead quickly and it is expected that the main section will be officially opened late next month.

Toronto is to have a new hospital, the Metropolitan General, which will be located in or near

Don Mills, one of the fastest growing suburban areas in Metropolitan Toronto. The new hospital is expected to have an initial capacity of 100 beds and the cost is estimated at \$2,225,000.

The Bingham Memorial Hospital in Matheson is being repainted. The first part of the two or three-year program will see the patients' rooms, halls, lobbies, kitchen, central supply and all outside woodwork done. Besides this, a separate bathroom for maternity patients has been installed and a new automatic dishwasher and electric stove have been purchased.

London's Victoria Hospital will soon begin a five-year expansion program which will cost an estimated \$4,000,000. Next year's plans call for a nurses' residence and nurses' training school, an addition to provide improved x-ray, laboratory and out-patient facilities, an operating room extension and enlarged central supply department and a staff cafeteria.

Brant Sanatorium in Brantford has opened a hospital division for the care of the chronically ill. Accommodation has been prepared which is completely cut off from the rest of the sanatorium. There is enough space for 30 beds. Cost of the rearranging and redecorating was about \$10,000.

Part of the new 350-bed \$5,500,000 addition to Ottawa Civic Hospital in Ottawa will be occupied this fall. By then it is expected that the wing's new emergency and admitting departments will be operating.

Meaford citizens were given the chance to inspect the 26-bed, \$200,000 addition to the Meaford General Hospital when the new hospital wing was officially opened. The wing has been in use since the beginning of the year and the continuous increase of patients indicates that the 26 beds were needed indeed. Architect for the addition—the Mackenzie Robertson Wing — was William J. Carswell, Collingwood.

Plans to make extensive changes at the Niagara Hospital, Niagara-on-the-Lake, have been approved. The changes will cost \$74,580 and will add six beds to the hospital. Alterations have been designed to make use of waste space in the basement. Food service will be improved and a new road and entrance for ambulances built. Gases and other supplies will be kept in a special store room, not in the hospital as they are now. The

emergency operating room and x-ray room will be moved downstairs.

Tenders have been called and received for construction of a dietary wing at the Kingston General Hospital, Kingston. Architects are Drever and Smith, Kingston.

Work on a new infirmary type of hospital in Huron County will be under way soon. At first this hospital was to be for mentally retarded children only, but now it is planned to take care of all types of mental patients there. It will be built on the shores of Lake Huron a few miles south west of Goderich.

Architects will proceed with detailed plans for the proposed addition to Victoria Hospital, Renfrew. The board of trustees approved the preliminary sketches prepared by Herbert Agnew of Agnew and Ludlow, Toronto. Total cost of the addition is estimated at \$1,486,281. The new plan calls for an addition that runs all around the present structure on the north, east and south sides. A basement on the north side will provide space for general stores, boiler room, laundry and autopsy room. On the ground floor will be emergency and out-patient treatment areas. There will also be a pharmacy, dietary department, physical medicine department, enlarged administrative areas and a medical records department. On the second floor there will be 68 beds as well as operating suites and recovery rooms. On the third floor there will be 35 beds and 34 bassinets.

Quebec

Hôtel-Dieu de Lévis in Lévis is planning a large expansion program which will increase the hospital's bed capacity from 235 to 400. Two new wings will be constructed, one of which will house the new school of nursing, large enough to look after 100 students.

For the first time in its history, Verdun Protestant Hospital in Montreal has a full-time resident chaplain. The new Anglican chaplain will work closely with the clergy of other denominations.

The sod has been turned for the new regional hospital in Lachute. The modern hospital building will have 80 beds and will provide quarters for the religious sisters on the top floor. There will be two operating rooms, an emergency department, an obstetrical depart-

ment and an eye clinic, as well as a radiology department, laboratory, pharmacy, et cetera. The architect is G. D. Thompson of Montreal; the cost is estimated at \$1,500,000.

The contract has been awarded for the construction of a 75-bed hospital at Sept-Iles. Plans are by Maurice Bouchard, Quebec City.

Hôpital Notre Dame in Montreal has become affiliated with the University of Montreal. Thus it has become the first hospital to sign an official contract of affiliation as a centre of teaching and research since the university's new charter in 1950.

New Brunswick

At a recent public meeting, about 175 citizens voted unanimously for a hospital in the Gagetown area. Chairman at the session was Dr. W. M. Jenkins, resident physician for over 50 years. He was elected to head the hospital committee and was among the first to donate to the hospital fund.

The wing of the Salvation Army's Evangeline Home and Maternity Hospital in Saint John has been opened. All hospital facilities will be contained in the two-storey, 15-bed addition. The older building will be used as a home for the girls who stay at the hospital, sometimes for several months. In the new wing is a beautiful nursery furnished with 12 mobile units, each containing bassinet, bath and a container for all the necessary equipment. The architects are Alward and Gillies of Saint John.

A poison control centre is being set up at the Moncton Hospital in Moncton. A card index system is being established with the help of the food and drug branch, Department of National Health and Welfare, Ottawa. Cards list the names and proportion of ingredients contained in various drugs, cleaning fluids, et cetera, as well as the antidotes.

Less than two years after the cornerstone was laid, a new \$2,500,000 wing was opened at the Saint John General Hospital, Saint John. The opening of the 260-bed wing marks the fifth phase in the hospital's multi-million dollar expansion program. The imposing eight-storey structure has doubled the hospital's accommodation space. It houses, in addition to many other facilities, a special section containing the radiotherapy department. ■



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Long-Term Patients
(concluded from page 38)

adapted to operate as a chronic unit.

Another serious difficulty which becomes apparent when payment for services is considered, is the fact that nursing homes are private institutions, operated for profit, and the measure of profit expected from the operation is frequently in excess of that considered reasonable by the rate board of the Hospital Services Commission. One further problem which exists in the finances of these institutions is that almost all of them have some capital debt, in the form of a mortgage. How this is to be handled in the light of certain existing legislation creates a difficult task for the accounting staffs.

For these reasons, the Commission has been extremely careful in its approach to the approval of nursing homes for the provision of chronic care. However, there are a few areas in the province where not enough chronic beds exist, and in these areas the Commission is considering the grant-

ing of temporary licensing to qualify nursing homes. The granting of recognition to these nursing homes is being given on the prior understanding that the community is undertaking to provide the chronic beds it requires.

In considering licensing of these nursing homes, certain criteria must be met by the nursing home. It is appreciated that some leeway must be given in individual instances, but the following are the important features.

(a) The building must be designed and maintained in a manner which will minimize fire hazards. The institution will be required to meet the fire prevention requirements in force in its locality, as well as those of the Commission.

(b) Any approved institution will be required to provide as minimal requirements the first six inpatient services listed in Section 2, paragraph (f) of the Hospital Insurance and Diagnostic Services Act.

(c) Admission will be only on a transfer basis from a public general hospital. It is intended that each approved nursing home be

allied to the nearest hospital for its source of admissions.

(d) Admission will be granted only to patients who are certified under Commission arrangements as chronically ill, or, on occasion, as convalescent patients.

(e) Each institution will be required to provide a designated number of its beds as standard ward accommodation.

(f) Reports and returns regarding patients will be submitted as required by the Commission.

(g) The nursing care of the patient must be directly given by a graduate nurse, or by someone under her supervision. A graduate nurse must be on duty in the institution at all times.

(h) Each patient must be under the care of a physician, who is responsible for the medical and nursing care of the patient.

It is hoped that by careful attention to these criteria, and by a regular inspection by the staff of the Hospital Services Commission, quality care in adequate surroundings can be achieved by nursing homes which receive Commission approval. ■



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Progressive Patient Care
(continued from page 40)

be a small unit of four to eight beds, preferably on the surgical floor and adjacent to the nurses' station. Along with this, or as an alternative, we would suggest that the recovery room, really a post-anesthetic room in most hospitals, be put upon a 24-hour basis. The feasibility of this idea depends on the amount of surgery and the isolation or otherwise of the recovery unit. Patients could then be left there for 48 hours, or even 72 hours, or until they were out of

danger. To a large extent this would serve the same purpose as an intensive care unit in larger hospitals.

As most quite small hospitals (under 40 beds) do not have enough surgery to warrant a 24-hour recovery room, the use of an especially equipped and staffed room, or rooms, on a patients' floor next to the nurses' station would seem most practical.

The Self-Help Unit

This unit has been described in various terms—as a self-help unit, a convalescent unit, or as a mini-

mum care unit. It is one for which we can see considerable use although not necessarily for the purposes some have had in mind. To illustrate, we do not see it becoming widely used as a convalescent unit because most hospital beds are so much in demand that when a patient becomes sufficiently convalescent to be moved to another part of the hospital, he will, in many cases, be expected to go home. If the patient is likely to go home in two or three more days, he will probably be left in the so-called intermediate area.

There is, however, a real need for some such type of accommodation in larger hospitals for the fair percentage of patients who do not need to be in costly accommodation with oxygen and suction outlets, two-way audio nurse call communications, tray service, concentrated nursing service and other features. These are the ambulatory patients in for a checkup, certain patients in for physical therapy, certain fracture cases, diabetic checkups, arthritics, hypertension cases and some endocrine cases. To these patients could be added a small number who are truly convalescent but must still remain in hospital for a period, such as cardiac patients, severe gastric ulcer and anemia patients. Convalescence should not be confused with long-stay care for the chronically ill.

A factor that one large hospital found quite formidable in attempting to move patients to a convalescent wing was a widespread resistance to transfer, even to a new and modern unit. Many patients get accustomed to their surroundings, to the nurses and to the patient in the other bed. Apparently they fear the unknown—new nurses, or the patient in the next bed elsewhere who may snore, or cough, or turn up his radio, or smoke cigars. Much of this can be overcome with time and the tactful handling of individuals, but it does indicate the desirability of not underestimating patient reaction.

The problem is to decide who should go into the intermediate zone and who into the self-help area. This is important in planning, for if the minimum care unit is to be confined largely to diagnostic or checkup cases, it will require much less space than if it is designed to include all (as above) who do not really need the intermediate type of care. If we assign a large number of beds to this minimum care or self-help unit,

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we can make some savings in the cost of construction by omitting a two-way voice nurse call system, piped oxygen and a few other features. We would still require, however, as much plumbing, the same or better room lighting, a somewhat smaller nurses' station and utilities, more up-patient space and the same general hardware and floor and wall finishes. In other words construction savings would be proportionately small.

The construction of more than a small unit with restricted facilities presents another difficulty. With increasing demand, our hospitals are needing more and more beds and, at peak periods, these beds in the minimum care units are going to be needed for acutely ill patients. Under such circumstances it would be regretted if a new unit had been constructed recently without having provided, at comparatively little additional cost, for a greater flexibility in use.

For this reason, although we would recommend a small self-help unit in larger hospitals, we would prefer to reduce emphasis upon a large self-help unit and be inclined to favour more provision of the intermediate or ordinary accommodation. It is our impression, also, that the boards of the majority of medium sized hospitals would prefer to equip adequately their new buildings, including the self-help unit, to ensure greater flexibility in use. The savings would then come from reduced staffing of minimum care units rather than from leaving out certain structural or equipment features.

From a practical angle, what could be done by the average hospital to provide some such type of self-service unit?

The simplest procedure would be to convert one of the older floors which possibly is not piped for oxygen and suction and has an old-fashioned nurse call system. A four-bed room could be set up as a dining room and another area as a lounge. True, this is not ideal, for the floor may be short of single or two-bed rooms with toilet, but it would let the hospital concentrate its more active care in the newer wings. Better would be a self-care hostel with prefabricated plumbing service units in the rooms.

If a long-stay unit is being planned, as is being done in a number of hospitals, one of the floors with more direct connection with the main building could be for these short-stay self-care patients.

In summary, the setting up of an

intensive care unit in general hospitals is advisable. The nature of this unit and the use made of it will vary considerably in different hospitals. Although we have reservations about the practicability of so-called self-help or convalescent units in most hospitals, there is need for units where normally those patients requiring a minimum of nursing care can be accommodated apart from the acutely ill. ■

Royal Vic Awards Certificates
Some 36 male attendants at the Royal Victoria Hospital, Montreal,

Que., received special certificates in recognition of their studies in anatomy, hygiene, physiology, bacteriology and practical nursing. All work in the hospital, and took a special course designed to increase efficiency and interest them in hospital work. Under the direction of T. M. Davison, a registered nurse in both Ontario and Scotland, and supervisor of attendants at the Royal Victoria, the men began training two years ago. It is hoped that perhaps the men will be interested enough to become, after further study and work, nursing assistants.

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Evaluating Schools of Nursing (concluded from page 45)

educational unit plays an important rôle in its self-evaluation and self-improvement.

Many conclusions will be drawn from the surveys, and these will be contained in the final report. However, there are a few comments that could be made now.

1. Before a program of national accreditation can proceed, we must have formulated in writing, criteria which will serve as a basis for evaluating the educational programs.

We recognize that the development of criteria by which programs are evaluated is a co-operative process in which all members should eventually be involved. This will take time, but we are pleased to report that this task is now beginning. These criteria will be the "base line" criteria. The others will be the schools' own objectives.

2. All schools participating in the project have agreed that a program of national accreditation would be most helpful in assisting them in the process of upgrading their educa-

tional program. However, it is recognized that a school improvement program should be a part of this total process.

3. It appears that with a program of accreditation of schools of nursing, there should be a similar program of evaluation of nursing service. Since the quality of our educational programs depends so greatly on the quality of the clinical field, it would be difficult to reach our goals in nursing education if such a program were not initiated.

4. In surveying schools, one could not help but be impressed by the interest and enthusiasm of all members of the staff of both hospital and school. It appears that some schools have worked diligently to continue raising their educational standards. In others it appears that there is the potential to maintain a better program than was observed in the evaluation.

Is accreditation one means of assisting these schools? Will accreditation lead the way to better nursing? The final report which is scheduled to be completed by this fall should contain information to help us answer these questions.

The published report, a part of the final phase, will be available to all those interested in this project. It will be studied by members of the Canadian Nurses' Association prior to their General Meeting in Halifax in June of 1960. At this time, the members will decide if a program of national accreditation of schools of nursing is desirable. This decision will no doubt have a considerable impact on the future course of nursing in Canada. ■

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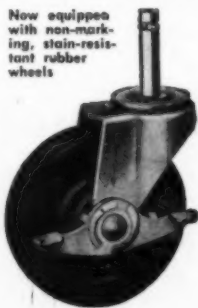
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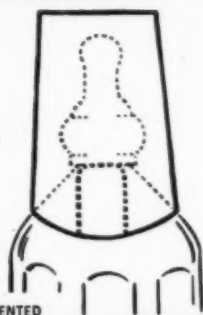
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From Canadian Hospital
August 1939

With everybody in the London area and out through the provinces taking war preparation seriously, it is to be expected that hospitals would do some camouflaging. Already some of the hospitals are looking like patch work quilts in green, buff and other identity-losing stripes. A "Life Transfusion" Service has been set up by the Medical Research Council in London and other large centres. An elaborate plan has been set up for the collection of blood from large numbers of donors living in the outskirts of London or in the West Country, such to be refrigerated and shipped by air or otherwise to wherever needed. As it is estimated that 100,000 donors will be required to meet the needs for Greater London alone, a very extensive system of donor registration is being arranged. These precautions are being taken in view of the Spanish experience that from five to ten per cent of the casualties, military and civilian, needed blood transfusions.

* * *

Winnipeg's "flower car" is interesting evidence of fine community spirit in that city. The *Winnipeg Tribune* has co-operated with Leonard and McLaughlin's Motors to distribute flowers in the hospital wards once a week. Each Wednesday, the "flower car" makes a tour of the city and collects fresh garden flowers from the private gardens of different citizens. The response to the request has been most generous and Wednesday has become a particularly pleasant day in the hospital.

* * *

We note in a recent copy of *Hospital Topics* that the Children's Hospital in London now possesses the rights to Barrie's immortal "Peter Pan". Walt Disney has found it necessary to get permission from the hospital before proceeding with work on his forthcoming cartoon movie based upon this story. In return for the rights to produce this movie, Mr. Disney has agreed to put on two benefit performances in London for the hospital. As this journal points out, this is "Just the kind of legacy you might expect a whimsical Scot to leave. It would be nice if other authors would leave copyright legacies to hospitals".

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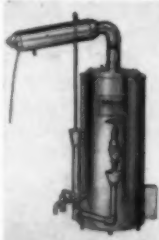


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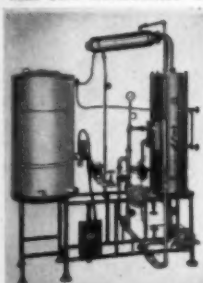
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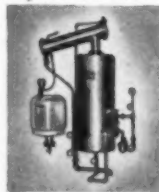
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C.D.A. Convention
(concluded from page 57)

more effectively in her professional rôle. The supervisor, trained in practical skills, and effectively directed, will be able to assume a great deal of the responsibility for lay work. There are training programs available for food supervisors which help them to develop management skills, develop them in their personal skills, and give stature and recognition to their position.

Ann Guthrie, the Violet Ryley-Kathleen Jeffs memorial lecturer, chose for her subject, "Today—A Grand and Awful Time". She is the United Nations representative for the International Alliance of Women. Horizons Unlimited, the challenging theme of our convention, suggests a glow of light across the horizon. Women all over the world share the three basic human needs—security, a little recognition and love. What will look grand and awful in 1999? It is the tremendous responsibility of all of us to hold steady, to help make the world a better place. There will be no peace in the world until there is rice for every mouth. She warned that it is our responsibility, as leaders in the world of food, to care about the world. We must not adopt the immature attitude of provincial people who feel that their small piece of the world is their very own. ■

Seminar on Alcoholism

A one and a half day seminar course for physicians, especially those in general practice, is to be held at the Alcoholism Research Foundation of Ontario, on November 13 and 14. Planned are three sessions of three hours each. At each session two or three members of the Foundation's medical staff will present short working papers on the nature of alcoholism—social background, psychopathology, physiology, organic pathology; medical management; and other factors in treatment.

Enquiries should be directed to Dr. John Armstrong, Medical Director, Alcoholism Research Foundation, 9 Bedford Road, Toronto 5, Ont.

New Address

The American College of Hospital Administrators is now located at 840 North Shore Drive, Chicago 11, Ill. The new address became effective June 8 this year.

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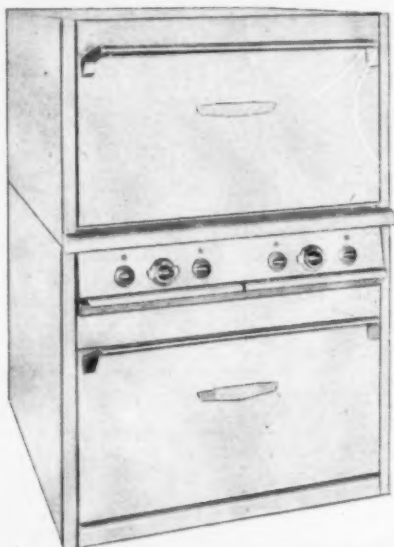
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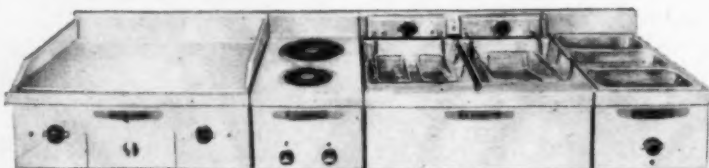
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Eighth Province Enters Hospital Insurance Scheme

New Brunswick has entered into an agreement with the federal government under the Hospital Insurance and Diagnostic Services Act.

New Brunswick's plan which became effective July 1, 1959, is operated by a hospital services commission and provides comprehensive hospitalization coverage for every resident of the province. The plan embodies a broad range of out-patient services—including laboratory procedures as specified by the commission and furnished by the provincial laboratory, services for emergency diagnosis and treatment of injuries resulting from accidents, diagnostic and treatment services required for medical rehabilitation, and other diagnostic and treatment services as specified by the commission. The provincial costs will come from premiums of \$4.20 a month per family, and \$2.10 for a single person.

O.H.S.C. Pays Daily

Since May 13, this year the Ontario Hospital Services Commission has issued daily cheques to the hospitals in Ontario in payment for services provided to insured patients. Up till this date the Commission had been paying the hospitals three times a month. The present system has been introduced as a number of hospitals found they could not meet current expenses without creating bank overdrafts, and, since practically every patient is insured, over-the-counter income had been reduced to a minimum. Therefore, ready funds were not always on hand.

Now, the cheques mailed out by the Commission cover approved accounts received the previous week.

Canada's Gift to Queen

The government, with the blessing of the Queen, has established in her honour a \$1,000,000 fund to provide financial aid to Canadian institutions and individuals engaged in research in children's diseases. This fund, to be known as the Queen Elizabeth II Fund for Research in Children's Diseases, marks an imaginative and constructive way of commemorating the Queen's visit, and follows the commendable trend being established for the royal tour, by settling up commemorative funds and scholarships instead of ostentatious gifts to the Queen.

Federal Grants

(concluded from page 60)

operated as an independent unit.

The Montreal Neurological Institute will receive \$8,000 to further investigations on developing safe techniques of extracorporeal cerebral circulation. The project is under the direction of Dr. T. R. Rasmussen.

Mental Health

A mental health grant of \$22,315 will help finance the gathering, correlating and evaluating of data on the incidence, nature and severity of emotional disturbances among medical students attending McGill University.

A grant of \$13,725 will aid research, under the direction of Dr. E. D. Wittkower associate professor of psychiatry, McGill University, Montreal, Que., into the impact of serious, prolonged physical illness of a child upon his family. It is hoped that much will be learned from the point of view of public welfare that will help the work of social agencies, educators, physicians and psychiatrists.

Another project, to study the effects of nucleic acids upon memory impairment in the aged will be helped by a grant of \$12,800. The study, a continuation of studies begun two years ago, is under the direction of Dr. D. Ewen Cameron, director, Allan Memorial Institute of Psychiatry, McGill University, Montreal, Que.

Public Health

A tuberculosis control grant of \$16,565 has been awarded to Manitoba to help comprehensive tuberculin testing there. The survey will be conducted in selected areas in the province but will eventually be expanded to include most people up to the age of 40, although, initially, only those over 40 and tuberculin reactors will be x-rayed.

A grant of \$28,785 will help the University of Toronto's faculty of medicine purchase an electron microscope. To be housed in the Banting and Best Institutes, it will be available for research to all departments.

A grant of \$37,500 has been made to the province of New Brunswick to enable the Hospital Services Commission there to set up a consultant service. The service will include consultants in nursing, dietetics, hospital administration, x-ray technology and hospital stores on a full-time basis, as well as a part-time research advisor and four part-time medical advisory consultants. ■



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People

(concluded from page 28)

tigonish, N.S., received his B.Sc. from St. Francis Xavier and his M.D., C.M., from Dalhousie University, Halifax, N.S.

He trained, too, at the Halifax Infirmary, Queen Mary Veterans' Hospital in Montreal, as well as at the Royal Victoria Hospital. Joining the staff in 1953, Dr. MacKinnon was made attending urologist in 1958 at the Royal Victoria. In 1956 he was appointed director of urology at the Montreal Children's Hospital, and became a Fellow of the Royal College of Physicians and Surgeons of Canada in 1952.

Named to St. Mary's

Appointed business manager for St. Mary's General Hospital, Kitchener, Ont., is Robert Cardy. Mr. Cardy, who has had several years' auditing experience, was business administrator of the Guelph Separate Schools before taking the hospital post.

Board Changes at Port Arthur

Elected president of the hospital board at the General Hospital of Port Arthur, Ont., recently was Gordon F. McDougall. Mr. McDougall takes over this post from Malcolm Cochran, who had been a member of the hospital's board for 27 years and president of it for 20 years.

• Albert Nantel, formerly assistant administrator at Hôpital St-Luc, Montreal, Que., has been appointed administrator at Hôpital Ste-Jeanne d'Arc, Montreal.

• Appointed administrator at Western Kings Memorial Hospital, Berwick, N.S., is Derek Bush. He succeeds H. C. Beals who has resigned from the post.

• New director of admission for the American College of Hospital Administrators is Dan Traner of Lynn, Mass. Mr. Traner, a former president of the Massachusetts Hospital Association will handle admission of new members and affiliate advancements within the College.

• Allan P. Alford, formerly administrator of the Winchester District Memorial Hospital, Winchester, Ont., is now administrator of Smiths Falls Public Hospital, Smiths Falls, Ont.

• R. S. Rigg, who was in charge of the Hydro hospital in Cornwall, Ont., during the building of the St. Lawrence Seaway, is now at The Arnprior and District Memorial Hospital, as administrator. Mr. Rigg is in his second year of the

C.H.A. extension course in hospital organization and management.

- J. H. Burrows has been appointed administrator at the Peace River Municipal Hospital in Peace River, Alberta.

- Dr. Honoré Nadeau, head of the medical clinic at l'Hôpital du St-Sacrément, and professor of medical dietetics at Laval University, Quebec, Que. has been elected president of the Société Médicale des Hôpitaux Universitaires. He succeeds Dr. Sylvio Le Blond.

- John P. v.H. van Soeren has been appointed executive director of rehabilitation services for the Co-ordinating Council for Crippled Children (Alberta) and for the Alberta Chapter of the Canadian Foundation for Poliomyelitis and Rehabilitation.

- Leo B. Doiron has been appointed to the Prince Edward Island Hospital Services Commission. Mr. Doiron, who holds a Bachelor of Commerce degree, and who has been managing director of the P.E.I. Credit Union League, will be in charge of hospital claims.

- G. A. Thompson, who has been on the board of trustees of the Kimberley and District General Hospital, Kimberley, B.C., since 1947 and chairman for the past three years, has resigned. Mr. Thompson, who is moving to Victoria, is succeeded by H. A. Howard.

Tribute to Sir Alexander Fleming

A special exhibit was devoted to the life and work of Sir Alexander Fleming, the discoverer of penicillin, at the International Hospital Equipment and Medical Services Exhibition which was held at Olympia, London earlier this year.

The exhibit, which included a reconstruction of Sir Alexander's laboratory at St. Mary's Hospital, was shown beside equipment demonstrating new techniques in the manufacture of penicillin. Much of the equipment for the exhibit was collected by Lady Fleming for a permanent museum of Sir Alexander's work which is to be housed at the Wright-Fleming Institute at St. Mary's Hospital, London. Among the articles on display were an authentic reproduction of the petri dish in which he first observed the important mould, his microscope and numerous manuscripts and awards.

Middle age: When you have that morning-after feeling without the night before.—*Davis' Nursing Survey.*

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Nurse Bursaries in Alberta

Effective January 1, 1960 the Alberta Blue Cross Plan will make available 30 bursaries of \$50.00 each for student nurses. This amount was decided upon because it was felt that the available money should be spent among a greater number rather than having fewer bursaries of a larger amount. The funds will be awarded through competition by students attending schools of nursing in Alberta, on the basis of one award for each unit, or fraction, of 30 students or fewer. To be awarded at the close of the preclinical training period, the bursaries will take into consideration not only successful grades, but promise of future attainment (15%) general attitude to nursing and patient care (35%), and need for financial assistance (50%).

The staff of the school of nursing in which the applicant is a student, will grade all applicants and will determine the winners of the awards.

Since the Alberta Blue Cross Plan has discovered that a large number of drop-outs occur during the first eight or nine months of training, the Plan hopes that its bursaries will make the difference between a student nurse's decision to leave or continue in nursing.

**Two-Day Conference on
Clinical Anticancer Drugs**

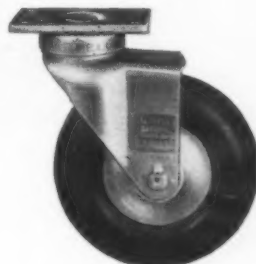
From November 11-12, 1959, the U.S. Public Health Services's Cancer Chemotherapy National Service Centre will hold a conference on clinical anticancer drug research in Washington, D.C., in the Hotel Statler. Under discussion will be the research undertaken by the Service Centre, and speakers will present papers on other phases of the chemotherapy program such as screening for anticancer activity, synthesis and pharmacology of potential anticancer agents, radiation and surgery as adjuvants to chemotherapy, and anticancer drug research abroad. Dr. B. H. Morrison, of the Service Centre staff, National Cancer Institute, Bethesda 14, Maryland, is in charge of arrangements for the conference.

Nursing Homes in Manitoba Plan

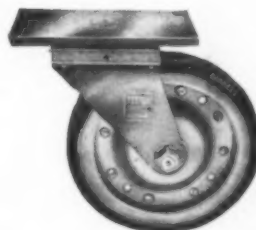
Nursing homes able to meet certain requirements of the federal government will be brought under the Manitoba Hospital Plan. The provincial government intends to set up a "standards division" to classify nursing homes.

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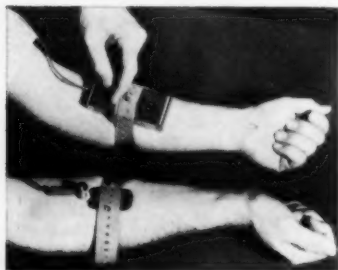
... Across the Desk

News Released by Hospital Supply Houses

By C.A.E.

Tiny Unit 'Beeps' Signals From A Heartbeat

A medical instrument that is expected to reduce surgical risks by signalling physicians instantly when it becomes necessary to perform heart massage or other forms of resuscitation was demonstrated at Atlantic City in connection with the recent annual meeting of the American Medical Association. It's the "heart monitor", a device less than five inches long and weighing only six ounces. It emits "beeping" signals translating the electric-wave activity of a patient's heart.



"Each human heartbeat produces one or more small electrical currents or impulses", said R. W. Burmeister, medical sales manager of the National Cylinder Gas Division of Chemetron Corporation, Chicago, the company showing the unit. "Measurement of the amplified electrical impulses gives a quicker and more accurate indication of heart condition than can be obtained by monitoring only the sounds of heartbeat, blood pressure or pulse."

"When this small self-contained instrument is strapped to a patient's arm and is turned on to transmit its signals," Burmeister said, "a surgeon listens for any interruptions or changes that may warn of a cardiac arrest or other heart disturbance. Operating-room personnel are thus all alerted instantly to a possible need for heart massage, injection of stimulants, administration of oxygen, electrical shock and other lifesaving measures".

The monitor uses a low-voltage, mercury-battery power supply and high-gain transistorized amplifier. It is usually strapped to a patient's left forearm, and an electrode, connected to the monitor by a small wire, is strapped to the patient's right forearm or other part of the body.

New Cardiac Suture

The development of an entirely new electrically conductive cardiac suture has been announced by Ohio Chemical and Surgical Equipment Company (a Division of Air Reduction Company, Inc.) Madison 10, Wisconsin. This is the first "new" suture in over ten years.

This special cardiac suture consists of a double-armed insulated conductor which may be applied directly to the myocardium for artificial stimulation of the heart. The suture is applied internally by means of a thoracotomy incision, directly to the myocardium.

Clinical observations indicate that there are no spasmodic contractions of the skeletal muscle with the new suture. This overcomes a prime difficulty often encountered with the application of

external electrodes. In addition, the Ohio cardiac suture may be left in the patient for long periods of time so that the necessity for re-opening the chest incision is greatly reduced.

The suture is silver-plated wire, braided over linen, insulated with polyvinyl tubing. One curved and one straight needle are swaged on each end. An adapter supplied by Ohio Chemical may be used to attach the suture to the Pacemaker. The electrically conductive cardiac suture is available in sizes 0 and 2.

For further information, write to Ohio Chemical Canada Limited, 108 Duke Street, Toronto 2, Ontario.

New Carnation Product



Instant Pasteurized Powdered Skim Milk is being introduced throughout Canada by Carnation Company Limited. Carnation "Magic Crystals" Instant mixes instantly and completely. It contains all the important protein, calcium and B-vitamins of fresh whole milk but only half the calories. Made from quality Canadian milk, it is produced at Carnation's new plant at Alexandria, Ontario.

Carnation Instant is available in four-quart and twelve-quart packages.

New Detergent-Germicide for Hospitals

A new soapless (anionic) detergent-phenolic germicide has been developed especially for hospitals by Huntington Laboratories. Called Di-Crobe Germicidal Cleaner, it will clean, disinfect and deodorize at the same time.

The carefully balanced detergent-germicide combination provides fine cleaning action and efficient germ-killing properties at a dilution of 1:60. Because of the absence of soap, it does not require rinsing and leaves an

(continued on page 92)

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Across the Desk
(continued from page 90)

active germicidal layer on surfaces cleaned. If desired, however, Di-Crobe will freely rinse off any surface.

Huntington officials say Di-Crobe can be used on all surfaces not harmed by water alone. Temperature or hardness of water will not deplete its effectiveness. Since Di-Crobe removes heavy soil safely and efficiently, it is excellent for use on floors.

Di-Crobe can also be effectively used in the operating room, to clean and disinfect the operating table, walls, fixtures and even the floor, because it does not interfere with electrical conductivity.

Private rooms and wards are other areas where Di-Crobe can be used to combat infection. A simple wiping process with Di-Crobe is said to kill germs on the beds, springs, plastic mattress covers, bedstands, dressers, furniture and all equipment used by the patient.

Huntington officials also suggest Di-Crobe be used daily in administrative offices, admitting offices, medical records offices, laboratory departments, X-Ray departments, the main lobby and cor-

ridors for great control of cross-infection.

Information on Huntington's complete hospital "patient safety" program and a Research Bulletin giving complete technical data on Di-Crobe can be obtained free by writing: Huntington Laboratories Limited, 86 Parliament Street, Toronto 2, Ontario.

New Image Intensifier

Keleket X-Ray Corporation has announced a new Image Intensifier which the company says is the first image intensifier developed with over 1,000 times intensification and convenient binocular viewing by the radiologist.

Developed in an effort to reduce patient and doctor exposure in x-ray diagnosis, the unit is one of several pieces of apparatus recently introduced. Included are high kilovoltage x-ray generators which produce sharper x-rays with less patient exposure and x-ray tables with improved shielding for x-rays present in diagnostic examinations.

In the Keleket intensifier, the image viewed by the radiologist has been intensified so that a greater degree of diagnostic in-

formation may be obtained in a shorter examination time. Contrast, brightness, and definition are greatly enhanced as compared to the normal fluoroscopic screen even though greatly reduced radiation levels may be used.

Keleket x-ray products are sold and serviced in Canada by RCA Victor Company Limited.

New Admission Procedures Described

A new admission procedure which provides all the necessary papers to get the patient to bed, and receive immediate professional service with one typing is described in a four-page folder available from The McBee Company Limited. The paper was written by Albert M. Ingram, Director of the Melrose Wakefield Hospital Association, Melrose, Massachusetts.

The system, developed by the Data Processing Division of The McBee Company, calls for a 19-part form made possible through Waxspot carbonizing. A special type-style of Royal Electric typewriter is also available for greatest legibility on copies. Write for this folder to The McBee Company Limited, 179 Bartley Drive, Toronto 16, Ontario.

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Make floor cleaning fast, easy and efficient the Geerpres way and watch costs drop. What's more, with Geerpres wringers, your mops last longer and do more work. Exclusive interlock gearing gives powerful but controlled squeezing action to force mop down and eliminate splashing. Wring a mop as dry as you please without twisting or tearing in a Geerpres wringer.

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Across the Desk

Shampaine Electric Lines Are Given Full C.S.A. Approval

Complete approval of the Shampaine Electric sterilizer and lighting fixture lines by the Canadian Standards Association (CSA) has been announced by H. George Skaller, president of the company.

The C.S.A. action follows the U.L. approval also granted to Shampaine Electric equipment operated by electricity or automatic controls. In addition, all Shampaine Electric sterilizers' comply with the design material and testing rules set down by the American Society of Mechanical Engineers (A.S.M.E.) and other boiler code agencies in the U.S. and Canada.

Slanted-Slot Bed Sign

Hollister Limited has introduced a versatile new bed and room sign that may be read with ease from any level, whether mounted low on a footboard or high on a wall or door. This is made possible by the unique slanted slot design of the new Line-O-Vision bed and room signs. This design increases the number of locations possible for sign placement.

The sign attracts staff attention to important orders for patient care and helps eliminate error. Varicoloured reminder cards can be read from across the room and cannot be misunderstood, lost, brushed or blown away. Plastic-coated reminder cards are available, with more than 120 standard wordings.



Clear safety panels slide out so the sign may be attached (screw holes are concealed underneath), then locked in place to protect the cards. The simple method of changing cards restricts use of the sign to hospital personnel. Made of shatter-resistant nylon plastic, the sign wipes clean with a damp cloth. It is available in a variety of sizes with a choice of sand beige or milk

white decorator colours. For further information, write Hollister Limited, 160 Bay Street, Toronto 1, Ontario.

Film on Cross Infection

Ways to combat a problem of mounting concern in hospitals, the occurrence and spread of staphylococcus and other infections, are outlined in a documentary film which had its premier on June 10 in Atlantic City at the convention of the American Medical Association in Ritz Hall of the Ritz-Carlton Hotel.

The half-hour colour motion picture, "Hospital Sepsis, A Communicable Disease", is jointly sponsored by the American Medical Association, the American College of Surgeons and the American Hospital Association. The production was made possible by a grant from Johnson & Johnson, New Brunswick, N.J., manufacturer of surgical dressings and various other medical products.

Through a case history, graphically illustrated by animations, prints and charts, the film demonstrates that control of bacterial infections in hospitals can only be achieved by the alert action of

(continued on next page)

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Across the Desk
(continued from previous page)

every element of the hospital team, from surgeons in the operating room to the maintenance personnel who scrub the floors and supervise systems of ventilation.

The film was written and produced by Churchill-Wexler Film Productions, veteran makers of medical and scientific motion pictures, of Hollywood.

"Hospital Sepsis" will also be shown at the annual convention of the American Hospital Association at New York's Coliseum in August, and at meetings of the American College of Surgeons in Atlantic City, and the World Medical Association which will be held at the Queen Elizabeth Hotel in Montreal, September 7 to 12.

The documentary portions of the motion picture were filmed under actual hospital conditions, with a real patient as the subject. The viewer meets the patient upon her admission to a private room which has been made germ-free in advance. Subsequent shots show how this patient, with a

ten-year history of boils and carbuncles, is a source of epidemic staphylococcal spread in everything she touches, including the air she breathes, unless there are ceaseless and total measures to set up germicidal and other barriers between her and the rest of the hospital population.

Copies will be available on a loan basis for showing to professional groups and requests should be addressed to Johnson & Johnson Limited, Montreal.

Surgical Spray Dressing

A new surgical spray dressing, called Rezifilm, that is said to be the first preparation of its type for pre-operative and post-operative use in preventing wound infections following surgery is available from E. R. Squibb & Sons. When sprayed on the skin it rapidly forms an adherent protective film which is strong, flexible and transparent. Surgical incisions may be made directly through the germ-killing film which does not have to be peeled off at the time of operation. The new product promises to be of

significant help in reducing post-operative wound infections because of its ability, when in contact with the human skin, to kill many if not all of the bacteria



present. In addition to its pre and post-operative advantages, Rezifilm is also particularly useful as a dressing for minor cuts, abrasions and bruises. The product is available from Squibb in two-ounce (avd.) aerosol dispenser cans.

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**Across the Desk
New Location For
Montreal Office**

Montreal offices of The British Oxygen Canada Limited have been moved from 5085 Cote de Liesse Road to 950 Brennan Street. Head office of The British Oxygen Canada Limited is in New Toronto.

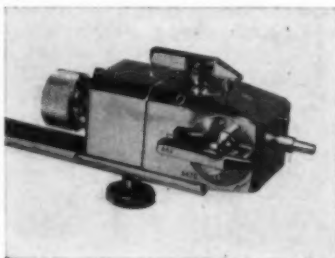
The appointment of William R. Holden, P.Eng. as manager, Montreal division of the company has also been announced.

Variable Reluctance Pressure Transducer for Intra-Cardiac Catheterization

Equipped with a standard Luer Taper for connecting hypodermics and catheters, the Telco type RA-8 pressure-sensitive head is designed for measuring pressures using direct punctures of the heart or blood vessels during surgery or for renal or hepatic catheterization.

When used with the Telco Manometer type M41, the pressure-sensitive head produces a direct indication of mean pressure on a meter, as well as making available an independent output for use in a photographic recorder, or an oscilloscope. Six ranges,

from 12.5 mm. Hg. to 400 mm. Hg. are provided, and the frequency response of the Manometer is adjustable to five different characteristics. The pressure-sensitive head incorporates an exclusive damping system, which provides critical damping, regardless of the type of catheter or needle used.



Further information on this product, and other Telco cardiovascular survey systems, is available from A. C. Wickman Limited, Electronics Division, P.O. Box 9, Station "N", Toronto 14, Ontario.

**New Testing Instrument
For O. R. Safety**

A new model Conductometer for testing the electrical resistance of personnel, flooring and equipment

in hospital operating rooms is now available. Conductometer Model H 90-500A, a portable instrument, permits existing hospitals to acquire this nationally known ohmmeter for use in their operating areas without breaking into the wall which would be necessary for the installation of the flush mounted Conductometer Model U L 90-500A. This portable model is furnished in a metal cabinet. A Conductometer may now be set up in each operating room, delivery room and emergency operating room with no alteration work involved.

Conductometer Model H 90-500A is identical in design to the Underwriters' Laboratories model, Conductometer Model U L 90-500A, now installed in hospitals in the U.S.A. and Canada.

The Conductometer's exclusive elbow switch permits personnel testing under aseptic conditions. Indicator scale is in colour and is easily read. The complete Conductometer unit comprises this electrically operated testing instrument, personnel test plates, testing electrodes for floor testing and

(concluded on next page)

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THE purpose of the Canadian Hospital Association library is to be of assistance to the personnel in Canadian hospitals. In addition to a fine collection of books, manuals, and pamphlets, the library maintains files of articles clipped from current journals on subjects pertaining to the various aspects of the hospital field. Packages are made up in accordance with specific requests. All material is available for a three-week loan period. There is no charge for this service. These packages are authorized as third-class matter and may be returned to the librarian at the rate of 2c for the first two ozs. or fraction thereof and 1c for each additional two ozs. or fraction thereof, or at the parcel post rate, at the option of the sender.

Across the Desk
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equipment test plates for equipment testing and meets the safety requirements of NFPA Booklet No. 56, May 1958, "Recommended Safe Practice for Hospital Operating Rooms".



For further information, write Conductive Hospital Accessories Corporation, 82 West Dedham Street, Boston 18, Mass.

**New Portable Appliance
For Indoor Odour Control**

Airkem Inc. have introduced a portable appliance called the Cavalier for odour control and improvement of air condition indoors. Intended for portable use, the durable, light weight unit weighs less than 11 pounds with a full charge of Airkem Solidaire—the new solid odour-counter-actant. The Cavalier will treat areas up to 1,000 square feet.



In addition to odour control the Airkem Cavalier adds a freshened effect to the air to combat the staleness and stuffiness frequently noticed in fully closed and heated areas.

Only 10½" high x 11" wide x 5¾" deep, the Cavalier features a silent, 2-speed positive air-flow circulating fan, adjustable odour-

control rates, and a unique, patented feeding mechanism for the odour-counter-actant. The odour-counter-actant magazine in the Cavalier is a zig-zag feeding device of a patented design which permits the Airkem service man to insert a charge of odour-counter-actant sufficient for several weeks of operation. The handsome steel cabinet is finished in two-tone grey with chrome trim. Power requirements are 110 volts A.C. for operation of the fan unit.

The Cavalier is available only through the national service organization of authorized Airkem distributors who also service the unit. Further information on the Cavalier and Airkem odour control services is available from Airkem Sales & Service Canada, 55 Kipling Avenue South, Toronto 18, Ontario.

**Porto-Lift Introduces
New Patient Scale**

Porto-Lift Manufacturing Company, of Roscommon, Michigan, is marketing a new patient scale developed for its patient lifting equipment.

The scale, which is graduated in half pounds and has a capacity of 300 pounds, is used to weigh patients in either a seated or



prone position. Because of its easy operation in conjunction with the Porto-Lift, it is now a simple matter to weigh any patient—particularly those confined to bed.

The new scale can be quickly attached for any weighing operation, and has been designed to fit all Porto-Lifts, regardless of the year manufactured.

Pollen Counter

The Kitchener-Waterloo Hospital in Kitchener, Ont., has a pollen counter on the roof of the main building. It consists of a metal stand with a special slot which holds a glass slide. This is coated with a preparation and will catch the various pollens as they are carried in the wind. The slide will be changed each morning and a pollen

count made.—*K-W-H News and Views.*

Television with Bedside Control

Two London engineers have invented an electronic modification to ordinary television sets which makes it unnecessary to go to the set to switch it on or off, adjust brightness or volume control, or to switch from one channel to another. A cable of any length to suit the viewer's requirements is plugged into the back of the set; connected to the other end is a remote control unit about the size of a small cigarette box. This contains volume control knob, brightness and on/off control knob, channel control press button switch, and jack plug for earphones.

Application has been filed at the British Patent Office for this invention, which, it is understood, has been subjected to every possible test over the last few months. It has obvious advantages for invalids whether in nursing homes, hospitals or at their own homes. Not only can any set now on the market be modified to take the unit, but whether or not it is plugged into the set, the latter can still be operated by the normal switches. The provision of a plug for the use of earphones is of great benefit to those with impaired hearing and also enables the set to be used without disturbing other occupants of ward or sickroom.

The promoters of the invention are directing their policy towards making sets with remote control available to hospitals, allied institutions, and welfare societies for short period hiring with free installation and maintenance, but without the need to pay nine months' rental in advance.—*Hospital Health and Management.*

Music for Hospitals

Background music may be an important feature in hospitals of the future. The Humber Memorial Hospital in Weston now has music piped into the main lobby, the x-ray waiting room, the physiotherapy waiting room, and the cafeteria. Arranged by Musak of New York, the melodies are soft and subdued and provide a pleasing background. No vocals are included.

It is hoped that the music will make both visitors and employees forget their blue Mondays and smile. Then the hospital will be a more pleasant place for all.—*Humber Memorial Hospital Highlights.*

Maintaining Sterilizers (concluded from page 48)

all drains to the front and out the drain line, the pitch is correct.

In summary, the operation of the following parts of the double shell steam pressure autoclave should be familiar to maintenance personnel of an efficient hospital and periodic inspections should be carried out as indicated.

Supply line strainer—inspect weekly until steam and boiler conditions indicate that a longer or shorter period between inspections is advisable.

Pressure regulator—remove renewal unit and clean if there is any indication that the cylinder is sticking. Be especially wary if any boiler compound has been added to the system.

Safety valve—check daily to ensure that the valve is not frozen in a closed position.

Pressure gauges—check for proper calibration and adjust if necessary.

Sterogage thermometer—replace if there is any indication of malfunction.

Sediment screen (discharge line)—inspect daily.

Air and condensation trap—remove and clean if there is indication that the bellows is sticking (as indicated by symptoms described above).

Jacket condensate return—remove and clean if there is any indication that the bellows is sticking (as indicated by symptoms described above).

An understanding of the operation of the double shell steam pressure sterilizer, and a simple preventative maintenance program for the equipment, will insure that these important adjuncts to efficient hospital operation are fulfilling the invaluable service that they provide in sterile procedure. Misuse or poor maintenance will be costly in terms of time, labour and replacement parts. But most important of all is the possible human suffering they can cause. ■

(Further information on maintenance of sterilizing and other equipment can be obtained by writing Wilnot Castle Company, 1911 East Henrietta Road, Rochester, New York.)

Films for Veterans

The film service of the Canadian Red Cross provides regular showings of current films for hospitalized veterans in 48 institutions throughout Canada.

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